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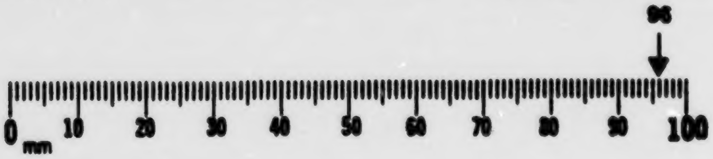
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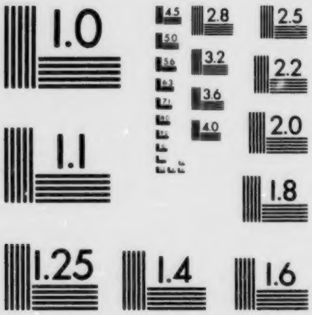
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A PROPOSED MODEL
FOR
NORTHEAST ONTARIO MENTAL HEALTH SERVICES

REPORT OF THE
NORTHEAST ONTARIO MENTAL HEALTH
STEERING COMMITTEE

SEPTEMBER 30, 1986

Spicer MacGillivray
Chartered Accountants

156 MCINTYRE STREET
NORTH BAY, ONTARIO P1B 2Y6
TELEPHONE (705) 472-6500

October 24, 1986

The Honorable Murray J. Elston
Minister of Health
Hepburn Block
Queen's Park
Toronto, Ontario
M7A 1R3

Dear Mr. Elston:

On behalf of the Steering Committee for the Northeastern Ontario Mental Health Study, I take pleasure in submitting our report, "A Proposed Model for Northeastern Ontario Mental Health Services".

The Report was developed by the Steering Committee, comprising of representatives from Northeastern Ontario, the Ministry of Health and the consulting firm of Touche Ross and Partners. It provides a review of mental health services and needs in the Northeast and recommends a model for the future provision of mental health services across the region. The redevelopment of North Bay Psychiatric Hospital and the development of mental health services throughout the catchment area are addressed.

During the study and development of the model, extensive consultation took place with health care providers, consumers and special interest groups with the assistance of questionnaires developed by Touche Ross and Partners, private meetings with special interest groups, public meetings and extensive dialogue with the local media. In my opinion the Steering Committee members made every effort to ensure that regional and local concerns were identified and addressed.

As a first step, I would like to suggest that the report be distributed throughout the Northeast so that interested groups and individuals have the opportunity to provide input to the implementation planning process. I would also like to suggest that the Chairman of the Implementation Committee be appointed as soon as possible to assist in the coordination of the distribution of the document, to provide for continued continuity and finally to demonstrate to the residents of Northeastern Ontario and the Health Care Providers the continued support for the redevelopment of Mental Health Services currently being provided for by you and your colleagues.

This will be particularly important in areas such as Sudbury where the report recommends fewer acute psychiatric beds than now exist, in Timiskaming which indicated interest in being a district planning area, separate from Nipissing, in North Bay where planning is in the advance stages for the construction of a new health care center and finally in Timmins and Sault Ste Marie where the recommendations also impact on their respective planning processes.

.../2

Montreal Ottawa Toronto Mississauga Brampton North Bay Sturgeon Falls Hamilton St Catharines Port Colborne Cambridge Listowel Goderich Winnipeg Vancouver

At present, there appears to be significant regional support for the proposed model, including the use of the North Bay Civic Hospital site for a chronic care facility.

I believe the Ministry should take advantage of the local and regional enthusiasm for mental health service development and immediately begin planning for implementation to ensure that these vital service initiatives, which are consistent with your overall health care objectives in the North, are realized.

In closing, I wish to express the Steering Committee's appreciation for the Ministry's commitment to enhancing mental health services in Northeastern Ontario. We trust our Report will be useful to the Ministry in planning future mental health services for our region.

If I can be of service or if you wish a meeting to discuss this document further, please do not hesitate to call.

Thanking you in advance.

Yours very truly,

Peter R. Birnie, C.A.
Chairman

PRB:lf

Encl.

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I. EXECUTIVE SUMMARY

In late 1984, the Minister of Health appointed a Steering Committee of representatives from Northeastern Ontario and the Ministry of Health to establish terms of reference for a comprehensive Northeast Mental Health Study.

The overall objective of this study was:

- **to develop a comprehensive and dynamic plan for mental health services for Northeastern Ontario to the year 2000.**

In order to achieve this objective, an understanding of current providers and establishment of future requirements was essential, including:

- a detailed inventory of existing mental health services;
- institution-based mental health service requirements, including in-patient and out-patient services;
- community-based mental health service requirements, including housing, counselling, outreach programs, vocational services and other support services; and,
- mental health service system requirements, in particular, program development, co-ordination and evaluation.

The Steering Committee met regularly throughout the study to discuss findings and conclusions and to formulate principles and directions for a model of service delivery. Furthermore, some of the Steering Committee members were highly visible throughout the past six to eight months in their own areas, promoting the study, encouraging interest and confidence that the result would be a realistic, flexible model. The role of the Committee members and their individual input to the study process should be highlighted as an important factor in preparing the Northeast for a new system of mental health care.

OVERVIEW OF NORTHEASTERN ONTARIO

The areas considered as part of Northeast Ontario are Algoma, Cochrane, Timiskaming, Nipissing, Manitoulin and Sudbury. The original scope of the study included Parry Sound as part of Northeastern Ontario. However, during the study the Committee took the decision that recommendations would not be made on a specific model for Parry Sound primarily because there were no representatives on the Steering Committee from the Parry Sound area, and referral patterns for Parry Sound residents are to both the North Bay and the Penetanguishene Psychiatric Hospitals.

The following are the major summary conclusions from the data analysis of Northeastern Ontario:

- The population in the Northeast is expected to remain relatively the same over the next 15 years, a 6% increase from 1981 to 2001 is expected.
- In terms of mix, the elderly group over 65 years is expected to increase most significantly and the number of children will decline.
- The land area in the Northeast represents 30% of total Ontario, while the population represents under 7%. The result is a significantly low density and a challenge to provide accessible services.
- Language and cultural characteristics vary significantly across the Northeast which implies the need for flexibility and responsiveness within any effective service delivery model.
- Within the region, a greater proportion of mental health expenditures is invested in institutions (65.9%) compared to the Province (59.6%).
- One of the challenges in developing a model for 2000 will be the shift in dollars from institution-based services to community-based services and enhancing the role of the primary care providers, especially GPs.
- The Northeast Region has 465 adult psychiatric beds and 32 children and adolescent beds; 66% of all beds are at the North Bay Psychiatric Hospital. However, other general hospitals throughout the Northeast Region also treat patients with mental illness diagnosis. In terms

of 1984/85 utilization, the following trends are noted with regard to where patients are treated:

Area	% of Separations Handled Within Area
Algoma	85
Cochrane	86
Timiskaming	78
Nipissing	91
Manitoulin	48
Sudbury	92

- It is apparent that most areas are handling the majority of their mental health admission requirements with current resources.

- In planning for mental health services for the Northeast, the two diagnostic groups which represent the majority of acute and chronic mental illness are schizophrenia and affective psychoses. The other mental health diagnostic groups are not readily quantifiable; therefore judgement and experience must be used in estimating requirements.

Some of the major strengths and weaknesses identified during this study are as follows. Many of the points listed below were common across the service areas.

The major strengths identified were:

- the dedication of existing mental health professionals, especially in small communities; and

- the number of basic services currently existing in large communities.

The weaknesses and gaps identified out-weigh the strengths. Interviews and questionnaires consistently highlighted the following weaknesses in the current mental health services:

- lack of children's services and waiting times for those which exist;

- lack of francophone services;

- lack of co-ordination and planning of services and lack of communication;

- competition amongst providers;

- lack of professionals and lack of training for community hospital staff;

- lack of programs and support services for ex-psychiatric patients;
- lack of preventative services;
- lack of services in remote areas;
- lack of public awareness and education;
- distance, isolation and geography of areas;
- disappointment with existing regional services.

TRENDS IN MENTAL HEALTH CARE

The need for an updated approach to mental health care for Northeast Ontario residents is a clear requirement for a model which is to have lasting value, well beyond the year 2000. With this in mind, an appreciation of the trends in mental health care in Canada and beyond is necessary. The major trends considered in this study include:

- the prevailing lack of a clear definition of "mental illness" and potential scope of the problem;
- the need to prioritize needs in order to use scarce resources effectively - focus on individuals with chronic psychiatric needs;
- the importance of primary care providers (gatekeepers) and good case management;
- the need for a balanced system of care;
- the need for management and control mechanisms; and
- the philosophy of humane deinstitutionalization and community-based supports.

INTRODUCTION TO THE MODEL

In order to develop the model of mental health services for Northeastern Ontario, it was necessary for the Steering Committee to establish general principles for the system with a vision to year 2001. Various models and trends in mental health care discussed in Section V are reflected in the nine principles of the model. An understanding of these operating principles and interpretation of each is critical to successful implementation and to the appropriate realignment of current providers and their roles within the system.

Principles

The principles of the model are as follow:

- The basis for the model is a comprehensive and balanced mental health system available and appropriate to all residents of Northeast Ontario.

- The model is developed on the basis that the individual client's needs will be the primary consideration in program design and priority setting for funding.

- The needs of the chronically mentally disabled are given foremost consideration, while recognizing that there is also essential need for acute intervention and preventative services.

- The mental health needs of the elderly living in chronic care facilities and nursing homes are addressed primarily within these settings with support from and access to the comprehensive mental health system.

- The services are provided in the least restrictive environment giving due consideration to the quality of life.

- The services will be provided in the client's community of preference, where it is possible and cost effective.

- The model ensures access to small or widely dispersed population centres.

- The model assumes there is an integrated mental health delivery system which is sensitive and responsive to the distinct cultural and linguistic needs of the population.

- The model will have a defined management infrastructure which includes program development and delivery, evaluation, funding and on-going maintenance.

Recommended Components of the Northeast Mental Health Model

The proposed model has an overall goal to build reasonable self-sufficiency within four designated service areas so that each will provide for the mental health needs of the population it serves. The four service areas are:

- Nipissing/Timiskaming;
- Manitoulin/Sudbury;
- Algoma; and
- Cochrane.

The need for a regional adult and a regional children's service is preserved in the model. However, the regional function becomes a more highly specialized function in the context of the total system of care. It is recognized that certain types of institution-based services are more cost effectively offered on a regional basis. It is not practical nor feasible to offer highly specialized programs in every area, considering the specialized professionals required for the services. The current regional services for Northeast Ontario are thus redefined and downsized significantly in light of planned enhancements to service planning areas and the trend towards community-based services.

- **Regional Services**

  The components of the model are:

  - a 26 bed adult secure service;
  - a 26 bed adult specialized developmentally handicapped service;
  - a 60 bed continuing care service for adults; and
  - a 10 bed children's inpatient service.

- **Area Services:**

  - adult community-based services:
    - case management,
    - supportive independent living program,
    - high/medium support housing beds,
    - drop-in centres,
    - employment opportunities,
    - community mental health centres/programs,
    - mental health promotion programs;
  - adult hospital-based services:
    - in-patient acute psychiatry beds,
    - ambulatory care services,
    - hostel (supervised housing),
    - crisis intervention programs,
    - geriatric outreach program;
  - children's mental health centres;
  - children's acute psychiatry services; and
  - addictions services.

The formal mental health system is supported and must network closely with other interest groups and agencies in the community, which may be funded by Ministries other than Health, such as social services and the educational system.

*** Redevelopment of the Regional Adult Facility**

The North Bay Psychiatric Hospital facility has undergone several architectural/ structural evaluations, all coming to the same conclusion, that necessary renovations could cost as much as re-building the entire facility. This required the Steering Committee to make a decision on whether to recommend use of the current site for redevelopment or move the adult regional psychiatry services elsewhere.

There were a number of options considered for location of the regional service in North Bay. The three main options considered were:

- the current site;
- the North Bay Civic site (which will become available when the new North Bay District Hospital opens); and
- the new District Hospital site.

The New North Bay District Hospital Site is recommended as the new location for the regional adult psychiatry services. There is ample property available at the site which is slightly outside the city centre with good public transit accessibility. Selection of this option fulfills the objective to bring psychiatry services into the acute health system. Staff become better integrated and stimulated through exposure to a more diverse health care environment. The Steering Committee believes that this option helps to reduce the stigma long associated with the "Psych on the Hill" bringing the service closer to the community.

As well, there are economies of scale and possible "savings" in annual operation costs in using one site for acute and regional psychiatry services.

*** Regional Children's Acute Psychiatry Service**

There are currently 32 regional children's in-patient beds funded by the Ministry of Community and Social Services located at the Sudbury Algoma Hospital.

It is recommended that a reduced number of regional beds be maintained in Sudbury (10 beds) for North-eastern Ontario only. The development of additional beds and programs in each service area will enhance accessibility and reduce the need for distant referrals.

It is recommended that this Regional service remain in Sudbury along with the 20 children's beds which service Manitoulin/Sudbury. A change in location was not considered for this service as it is recognized that the recruitment of children's experts is often difficult and that significant expertise is currently available to support the 32-bed function in the city of Sudbury. Transfer of the service to the Ministry of Health is recommended.

Organization and Management

A well-defined management infrastructure is essential to ensure program development and delivery, evaluation, funding, and ongoing maintenance of the proposed model. Sound management impacts directly on the success of the future system to fulfill the principles and vision established for the model in year 2001.

The establishment of four Community Mental Health Management Boards (CMHMB) are recommended to be responsible for the range of community-based services in each service area.

Each CMHMB will have on its Board a range of representatives from the population it serves. To this end, a mix of providers, both local and regional, children's representatives, concerned citizens and special interest groups should be included. The major objectives of the CMHMB are:

- to monitor and ensure that an appropriate range of community mental health services is in place for the service area;
- to develop, operate and evaluate community-based mental health services as required throughout the service area;
- to work co-operatively with social services and hospital-based mental health services to ensure a co-ordinated delivery system;
- to identify new community mental health service needs in the service area; and,

- to make recommendations to the local District Health Council on mental health needs and program priorities for the service area.

The relationship to the Ministry of Health is direct as funding will flow to the CMHMB for allocation to the various programs. The scope of responsibility of a CMHMB under this model might be 110 to 220 staff and require the management of a budget of an estimated $4 to 8 million a year.

Planning and Evaluation

The Steering Committee supports the idea that a "Northeast Regional" voice is required to promote the interests of its residents, especially for regional planning and service issues, university affiliation and representation on key issues to Queen's Park. It recommends that the District Health Councils' Mental Health Sub-Committees meet on a regular basis, as they reportedly do now, and identify and plan for mental health service issues that are of a regional nature. With regard to local planning issues, it is essential that the CMHMB have representation on the District Health Councils' Mental Health Sub-Committees to provide the necessary input to make planning and program priority recommendations for their service area. To this end, it is timely for the unorganized areas of Nipissing and Timiskaming to establish a District Health Council in order to ensure adequate representation at the Regional level and to plan for and co-ordinate mental health services.

It is critical to this model's ongoing success to have a systems-wide evaluation component which will monitor the implementation and ongoing needs of the Northeast population. Some of the important players in the evaluative process will be:

- District Health Councils;
- Ministry of Health;
- Community Mental Health Management Boards;
- hospital-based services;
- professionals;
- consumers; and
- universities and community colleges.

One important challenge will be to develop an information system which is common to both institution and community-based services and covers Ministry of Health and Ministry of Community and Social Services programs. The information system must also produce data which relates to goals of the individual programs and of the overall system.

Some of the major issues which need to be addressed through ongoing evaluation include:

- comprehensiveness and balance;
- accessibility;
- continuity of care;
- flexibility and responsiveness to changing needs; and
- client need, satisfaction and outcome.

University Involvement In The System

This study recognizes the importance of the involvement and interest of universities in the ongoing development of the mental health services system in the Northeast. The major reasons for such involvement include:

- human resource levels for the regional, specialized care facilities;
- psychiatric support to the general hospital psychiatric unit;
- re-education for a range of mental health professionals;
- assistance to community colleges in developing appropriate programs;
- research, especially collaborative and clinical; and
- evaluation procedures and tools.

The University of Western Ontario has been involved for some time in the delivery of mental health services to the North though it's extended campus program. In recent months the Ministry of Health has funded a Northern Co-ordinator position, responsible to the University of Western Ontario and Laurentian University, with the intent of introducing more psychiatrists and other mental health professional programs to the North.

This study supports this move and recommends that the Co-ordinator position be linked formally to the regional planning and evaluation group. As well, this position should work with the University of Ottawa to bring the necessary francophone resources and programs to the Northeast.

IMPLEMENTATION OF A COMPREHENSIVE MENTAL HEALTH SYSTEM

This report is intended to provide a starting place and vision for a comprehensive and balanced system of mental health care for Northeast Ontario. As discussed throughout, one major thrust is towards developing reasonable self-sufficiency within the four service areas by ensuring that an essential continuum of services is in place and accessible to all residents.

To this end, one challenge will be to build upon existing strengths and the expertise of current providers. The fact that each service area begins at a different starting place means that flexibility and creativity is required in applying the model. For this reason, the proposed implementation is complex in that the four service areas each face their own unique challenges. Algoma and Cochrane must expand their acute hospital psychiatry services; Manitoulin/Sudbury must negotiate reductions in beds. Nipissing/Timiskaming is challenged to develop a comprehensive health complex in North Bay and re-distribute resources to Timiskaming which has one-third of the service area population. Enhancements to community-based services are required across all areas.

Implementation Start-Up

The first year will be critical to successful implementation. During this year it will be necessary to establish sound leadership and accountability for a lengthy implementation. To this end, a Minister's appointed Northeast Implementation Committee is recommended to oversee the process of implementation and to ensure that activities within the service areas are consistent with the overall model and are accomplished in a logical timeframe.

There is also a need to address specific issues related to the North Bay Psychiatric Hospital, its development on a new site and redeployment/staffing issues. It is recommended that a task force comprised of government and local provider representatives be established to manage these issues.

The third important start-up activity will be discussions between the Ministry of Health and Community and Social Services about this report's recommendations, specifically the proposed transfer of responsibility for the regional children's inpatient services.

It will be essential from the start of implementation to educate the public on the model and prepare communities within the service areas for responsibilities in caring for chronic mentally disabled and to enhance awareness around crisis intervention, prevention, acute psychiatry and ambulatory care programs which will become more accessible under the model.

Final Steps

Within 6 years of implementation start-up, the service areas should have assumed their new roles under the model. Housing, case management and SIL programs will be well established and the regional psychiatry facility should be opening in North Bay on the new North Bay District Hospital site. The role of the new regional psychiatry service will have been defined and individual patients assessed as to their needs for continued hospitalization.

As early as year 3 of implementation, some of the current psychiatric patients at North Bay Psychiatric Hospital could have treatment plans and a case manager to enable them to live in the community. Some patients may want to return to their home service area in light of the services which will be available. In any event, individual patient assessment by a team of professionals including a case manager, psychiatrists/GPs, nurses and social workers should be conducted and re-evaluated on an on-going basis.

The opening of the new regional psychiatry service and new District Hospital requires the 78-bed psycho-geriatric unit to remain at the North Bay Psychiatric Hospital until renovations of the Civic site can be completed. By year 8, it should be possible to close the current North Bay Psychiatric Hospital site.

COSTS

The proposed model requires a significant financial investment on the part of the Ministry. It is estimated that a capital investment of $60 to $70 million is required to ensure an appropriate level of hospital-based services are in place. This includes an additional 36 beds for Algoma, 33 beds in Cochrane, 80 beds in Manitoulin/Sudbury. This cost includes approximately $40 million to build the new regional and acute psychiatry facilities in North Bay for a total 155 beds and to renovate the Civic Hospital for 78 geriatric patients.

Annual operating costs are estimated relative to staffing of the mental health system, considering both hospital and community-based services. It is estimated that there are currently 1,150 to 1,160 mental health positions in the system, 605 of these positions or half of these are dedicated to regional services.

By year 2000 there will be an estimated 1,300 to 1,500 mental health positions in Northeast Ontario. This includes several Ministry of Community and Social Services funded programs, such as family life centres, children's mental health centre and children's acute care beds. These positions reflect an increase of 193 to 360 over current levels. The estimated cost related to these enhancements is $6.7 to $12.7 million. Annual staffing costs to operate the recommended model are estimated at $46 to $54 million including $600,000 a year to operate four Community Mental Health Management Boards.

II. BACKGROUND TO THE STUDY

The deinstitutionalization of chronic mentally ill patients has been a major thrust in mental health care in the last 20 to 25 years. In accordance with this trend, the role of provincial psychiatric hospitals has been redefined, becoming more highly specialized, and greater importance has been placed on general hospital psychiatric services and community-based services.

The scope and implications of these trends in the mental health service system have produced new challenges. Issues related to community attitudes, the adequacy of a comprehensive community support system and the training and availability of mental health professionals are all in evidence today. The challenge is not only to provide appropriate and sufficient services, but also to manage and co-ordinate a system which is flexible and ensures the chronic mentally disabled access to a continuum of both community and hospital-based programs.

The Ontario Ministry of Health has identified mental health as one of its major priorities. As a result, it has undertaken initiatives in the last 10 to 15 years which support deinstitutionalization, decentralized non-institutional services, and co-ordinated planning and management of a wide spectrum of mental health services. The latter is evidenced by the formation, in the Fall of 1982, of the Mental Health Division responsible for provincial psychiatric services and community mental health services.

At the same time, the Ministry of Health accepted responsibility as the "lead Ministry" in several other related areas, such as housing and social programs, to ensure that the non-medical needs of the chronic mentally disabled are identified and provided for by the appropriate provincial Ministry, agency or other level of government. Therefore, in planning and monitoring the provincial mental health service system, the Ministry of Health faces challenges of inter-Ministry and inter-agency planning and co-ordination.

A specific initiative which the Mental Health Division has undertaken has been the review of the role and operations of a number of the provincial psychiatric institutions (e.g. the Whitby, Lakehead and Brockville Psychiatric Hospitals have all recently undergone reviews). In planning a similar review of the North Bay Psychiatric Hospital there were some special circumstances to consider. Foremost was the physical plant which needed significant redevelopment or replacement. Therefore the issues which needed to be addressed were not only the Hospital's role and function, but also its location and the design of a new physical plant. This presented an opportunity for the Ministry to commission a much broader study of mental health needs and approaches to better serve all Northeast residents.

To this end, it was felt that the Northeast with its vast catchment area could benefit from a more decentralized system of care. In commissioning this study, the Ministry wanted to ensure that the redeveloped regional facility and essential components of a new mental health service system would be representative of the highest standards and most current thinking in mental health care. Northeast providers have long recognized the need for a more creative system of care with improved balance between the role of hospitals and community-based services.

SPECIAL ISSUES IN THE NORTH

The demand for mental health services in the North are consistent with similar trends across the Province. It is recognized that mental health needs are affected directly by family changes, the increased number of single parent families, economic and employment stress, the growing proportion of elderly, and the abuse of alcohol and non-prescription drugs. However, the challenge of meeting these needs through a comprehensive delivery system is far greater in the North than in most, if not all, other parts of the Province. The Ontario Council of Health's 1979 Agenda for Action on Mental Health Services in Ontario described factors of:

> "climate, isolation, distance, high cost of living, significant shifts in communities' economic base, lack of advanced educational opportunity and cultural diversity which place Northern residents at risk".

The report suggested that Northern Ontario was, therefore, in "double jeopardy" with regard to mental illness. The report recommended more extensive study in the North and identified significant, visible needs of the native peoples, women, elderly, and francophones. The need for better co-ordinating mechanisms was also mentioned as a priority.

The 1980 Study of Psychiatric Manpower in Ontario illustrated extreme shortages in the North and again highlighted the need for francophone/native psychiatrists and stronger university affiliation. It, too, pointed to a need for further study in the North.

Upon such recommendations, the Ontario Ministry of Health provided funding for the 1981 Joint Northeast Mental Health Study conducted by the three District Health Councils (Algoma, Cochrane, and Manitoulin/Sudbury) with representatives from the North Bay Psychiatric Hospital. Consulting assistance was provided by the Clarke Institute of Psychiatry and the Health Care Research Unit of the University of Toronto. The study identified key providers in mental health services and provided demographic data of the service area. Data collection included a survey to assist in the identification of needs throughout the Northeast, but the Task Force was careful to point out that needs are difficult to identify and that:

> ..."there are very few standards in the field by which 'need' can be measured,... in the absence of guidelines or standards (for psychiatric beds and professional staff) the determination of needs tends to become a rather subjective exercise."

Their study identified exhaustive lists of needs reported by providers and practitioners. The 13 recommendations in this report which appear in Appendix A spoke to the need for a Regional Mental Health Services Committee, for more professionals with on-going educational opportunities and for changes required in the Homes for Special Care Program. They also highlighted a need to assess quality of care for the chronic mentally ill patient and the need for post-hospital information systems.

Promotion and prevention were identified in the 1981 report as a community responsibility under District Health Council leadership. It was recommended that native representatives be involved in committees to improve mental health services and that french-speaking psychiatrists and professionals were needed. Recommendation 6 stated that:

> "North Bay Psychiatric Hospital should be designated as the regional centre for long-term care, back-up support for local mental health services and the treatment of difficult patients."

The Ministry of Health has been criticized for not acting on the recommendations of the Task Force. It should be noted, however that the original objectives of the 1981 study were very specific; to provide an overview of mental health services and assess the needs of particular communities and was not designed as a planning study. To this end, it provided important background information for this mental health study.

Dr. Heseltine's Towards a Blueprint for Change prepared for the Ministry of Health, is the much quoted document which has outlined various approaches and new directions for mental health care in Ontario. Dr. Heseltine specifically noted the

North as being an underserviced area and stressed the fact that good mental health planning requires prioritization of needs within the population in order to make effective use of scarce resources.

Since the report's publication in 1983, the overall directions suggested by Dr. Heseltine have been endorsed by the Ministry of Health's Mental Health Division as a vision for the future. In light of it's importance, this report includes references to the Blueprint for Change in the later discussions of trends in mental health care.

Also pointing to the need for change, the Ontario Public Services Employee's Union (OPSEU) sponsored a public hearing to discuss the state of mental health care. The summary of the session entitled "We Are All Guilty" included proceedings which identified extreme deficiencies in the current psychiatric care system and specific concerns related to the approach to care at North Bay Psychiatric Hospital. Specific recommendations were made concerning the need for a comprehensive range of community-based programs, introduction of crisis intervention services and approaches to safe deinstitutionalization with essential case-management and after-care program. The specific recommendation that:

> "Health service integration should be studied with the aim of having psychiatric patients treated with the same non-stigma regards as medical patients, and in the same community health facility",

was specifically considered by this study's Steering Committee and is discussed later in this study.

In light of these, and other numerous studies (listed in the Bibliography) conducted by District Health Councils, hospitals and other providers, it is not surprising that residents of the Northeast expressed concern that another study was being commissioned. For this reason, it will be important that action be taken to endorse and implement this study's recommendations within a reasonable timeframe.

DIRECTION FOR THIS STUDY

In late 1984, Minister of Health, the Honourable Alan Pope, appointed a Steering Committee of representatives from

Northeast Ontario to establish terms of reference for a comprehensive Northeast Mental Health Study. The study was to go well beyond past efforts in providing a model and vision for the future with a practical implementation strategy and timeframe for achievement.

The twelve appointed members to the Steering Committee and their area of residence appear in alphabetical order as follows:

Mr. Peter Birnie, Chairman - North Bay

Mr. David Butler* - North Bay

Mrs. Margaret Dobie - Sault Ste. Marie

Mr. David Doyle - North Bay

Mr. Tom Elliot - North Bay

Mr. Nick Hirt - Sault Ste. Marie

Mrs. Maureen Lacroix - Sudbury

Mrs. Shirley Rokeby - Timmins

Mr. Maati Saari** - North Bay

Mrs. Nancy Thompson - Tarzwell

Mr. Robert Trahan - Hearst

Ms. Coral Young - North Bay

Ministry of Health Representatives were also designated as members of the Steering Committee including:

Ms. Giah Eisenstein - Director, Mental Health Planning Branch;

Mrs. Karen Riehm - Senior Planning Officer, Mental Health Planning Branch; and

Mr. David Belyea - Senior Administrative Consultant, Northern Area Team, Institutional Operations Branch.

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* Relocated outside Northeast Ontario before commencement of the study.

** Resigned as of April, 1986 for personal reasons.

The Steering Committee first met in February 1985 to establish Terms of Reference for the study which appear in Appendix B.

Touche Ross Management Consultants were selected and the study began in September, 1985. The Touche Ross team was assisted by a highly qualified Psychiatrist Associate.

Because of the nature of this study, it was especially important to have significant direction and judgement from a psychiatrist's perspective. To this end, the expertise of Dr. Erhard Busse, as a Touche Ross Associate is reflected throughout this report and in the proposed model for Northeast Ontario. In light of his contribution to this study, the reader may be interested in Dr. Busse's background and specifically his experience as a practitioner in the Northeast.

> Dr. Erhard Busse, M.D., F.R.C.P. (C) has been a practicing psychiatrist for over 15 years and is currently Chief of Staff at the Oakville-Trafalgar Memorial Hospital. He has been with the Hospital since 1976 and during this time established the Department of Psychiatry. He has also been involved in the design and implementation of a comprehensive consultation program for Oakville high schools and for the Halton Juvenile and Family Court. Dr. Busse designed, implemented and supervised a comprehensive community-based case management and service program for chronic schizophrenic patients and is the co-founder of the Oakville Friends of Schizophrenics organization. He has been involved actively in the Halton District Health Council, having been a member of the Council and Chairman of the Mental Health Sub-Committee for five years.
>
> From 1974 to 1976, Dr. Busse was in private practice in North Bay and during his stay in this community, he served on the Board of Directors of the Children's Aid Society, provided management and clinical consultation to project DARE of the Ministry of Correctional Services and planned and implemented a program for hyperactive children for the local Board of Education. He also served on a regional committee which studied and planned for children's services and was involved in the design and implementation of a joint program for adult psychiatric patients which required the co-ordination of mental health services with the Ministry of Community and Social Services.

During his stay in North Bay, Dr. Busse became acquainted with the complexities of delivery of mental health services in Northeastern Ontario. He had clients from as far away as Kapaskasing and Sault Ste. Marie. Dr. Busse worked with the local Bar Association in developing informal mechanisms to provide for better management of psychiatric patients and had regular program contact with the local Vocational Rehabilitation Services of COMSOC.

Dr. Busse has a strong commitment to the creation and maintenance of a network of services for chronic mentally ill patients and, as a result, many of the programs at the Oakville-Trafalgar Hospital are collaborative projects between the Hospital, the local Public Health Unit, visiting homemakers and various volunteer organizations.

* * * * *

This report presents the findings, conclusions and recommendations of the Northeast Ontario Mental Health Steering Committee to establish directions for mental health services to the year 2000 and beyond. Its recommendations are far reaching and can be expected to touch the work of every mental health provider and interested member of society. While this report is lengthy, the reader is encouraged to spend time with each section in order to comprehend the rationale for the recommended model.

The sections which follow outline the objectives of the study and work program followed by an overview of the Northeast Ontario area demographics and characteristics. Subsequent sections describe current delivery trends, the proposed model for Northeast Mental Health Services including principles upon which the model is based and proposed organization and management of the community-based system. Applications of the model within each service area are then provided which consider existing services and their strengths. Finally, the implementation plan is presented with timing, and related cost estimates.

Extensive appendices include a bibliography, study terms of reference, lists of organizations interviewed, questionnaire highlights with respondent roles in mental health, demographic detail and utilization data. As well, other supporting detail are included.

III. STUDY OBJECTIVES AND WORK PROGRAM

In order to address successfully the requirements for this study, the Steering Committee established objectives which required the completion of comprehensive data collection activities followed by model development, testing and refinement. Extensive community consultations at various decision points throughout the study were held to maximize input by providers, general practitioners and the community-at-large. This was considered essential to ensure that the directions set in the study would build upon current strengths and promote a mental health system which is comprehensive and creative but practical in light of the identified needs of major user groups.

Objectives of the study and discussion of key activities in the work program follow.

OBJECTIVES

The overall objective of the study is:

- **to develop a comprehensive and dynamic plan for mental health services for Northeast Ontario to the year 2000.**

Having completed the study, it is suggested that the proposed model/plan, properly implemented, will have lasting value well beyond year 2000.

In order to achieve this objective, an understanding of current providers and establishment of future requirements were essential, including:

- a detailed inventory of existing mental health services;
- institution-based mental health service requirements, including in-patient and out-patient services;
- community-based mental health service requirements, including housing, counselling, outreach programs, vocational services and other support services; and,
- mental health service system requirements, in particular, program development, co-ordination and evaluation.

As set forth in the study terms of reference, the plan was to address the basic requirements for a comprehensive mental health service system, and as appropriate, consider special features and characteristics of the Northeast catchment area and its residents such as:

- the need for acute and chronic mental health services;
- the need for addictions services;
- possible integration and co-ordination of adult and children's mental health services;
- the needs of specific target populations, e.g. francophone, natives, psychogeriatrics;
- the role, size, location and university affiliation of North Bay Psychiatric Hospital;
- issues of assessment, follow-up and linkage between institutional and community care with respect to aftercare;
- issues of access and distribution; and,
- utilization and preservation, where possible, of the strengths and resources within the existing mental health system.

The final plan was to include a specific strategy for implementation in the context of a continuum of care and include the number, size, location, type and distribution of the resources required, and the redeployment and retraining requirements of existing human resources. Furthermore, recommendations for the future model were to consider:

- the most effective use of existing services;
- client needs, which could only be met through new or expanded programs; and,
- the relative urgency of services and programs and their ranking.

A final aspect of the plan was to be an approach and strategy for ongoing evaluation of the system.

In order to meet these requirements it was necessary for the consultants to undertake very specific data collection activities, report to the Committee the findings and present various options and scenarios for consideration.

WORK PROGRAM

The study began in September, 1985, and as shown in Exhibit 1, the Steering Committee met regularly to discuss findings and conclusions, and to formulate principles and directions for a model of service delivery.

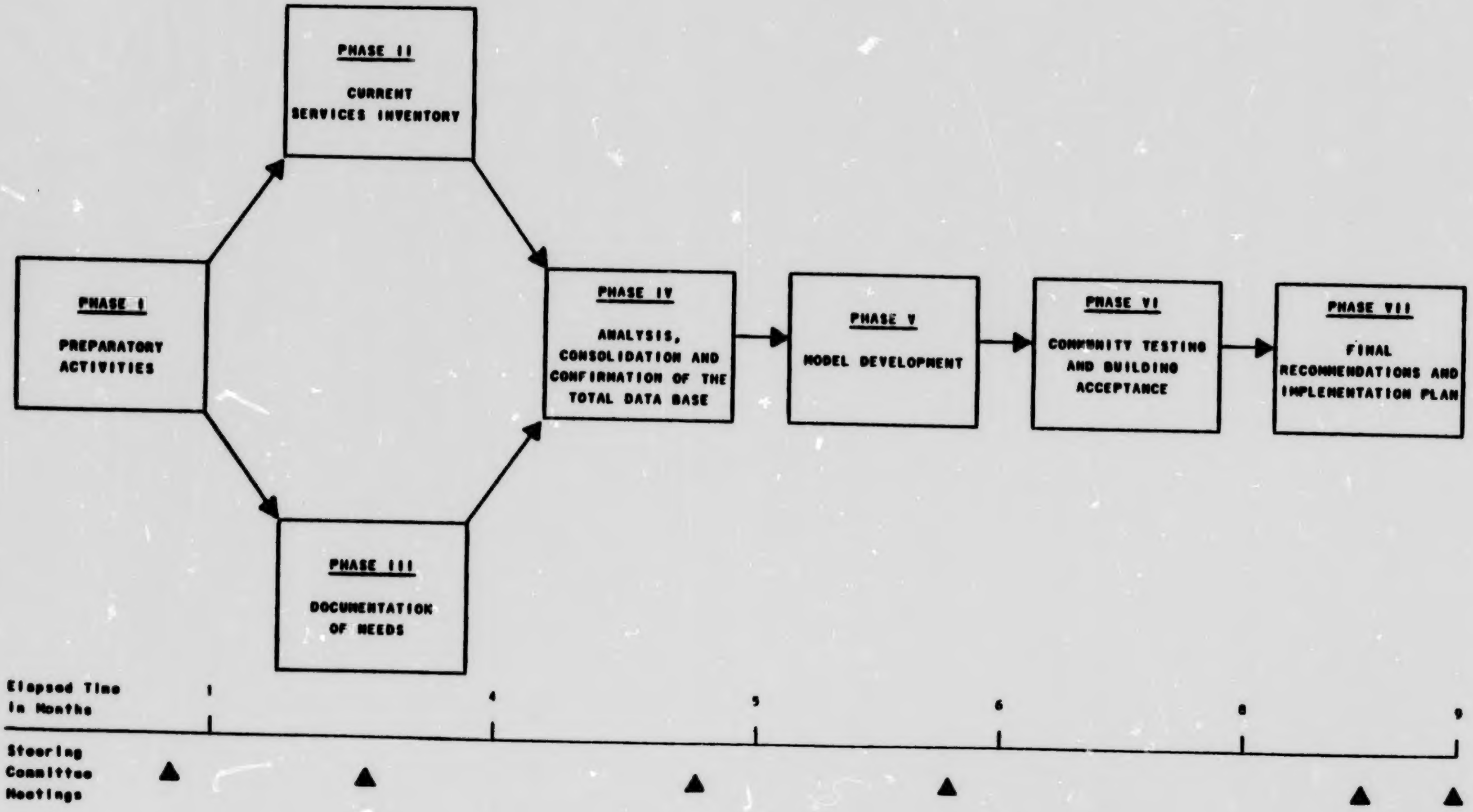
Furthermore, some of the Steering Committee members were highly visible throughout the past 6 to 8 months in their own areas, promoting the study, encouraging interest and confidence that the result would be a realistic, flexible model. Committee members took active roles in identifying key interviewees for the initial interview process, and assumed leadership roles in public consultations and model testing sessions. Members were encouraged to travel the North with a view to developing an understanding of the broader issues of the Northeast, beyond their own service area/community. The role of the Committee members and their individual input to the study process should be highlighted as an important factor in preparing the Northeast for a new, leading edge system of mental health care.

The major aspects of the work program included:

- a comprehensive review of reports, articles, program descriptions, position papers and pamphlets (included in the Bibliography);
- interviews in October and November, 1985 with over 150 key providers, associations, related agencies and user groups (included in Appendix C);
- development, distribution and analysis of questionnaires sent to general practitioners, providers and other groups (responses and list of respondents and their roles in mental health appear in Appendix D);
- a review of utilization data for Northeastern Ontario hospitals in providing acute/chronic mental health services, considering diagnostic categories, average length of stay and referral patterns;
- a review of demographic and mental disorder trends to establish projections for the major diagnostic categories;
- a review of provincial expenditures in mental health and Northeast Ontario share in total and per capita;
- development of an inventory of existing mental health services (including non-health funded agencies and groups);

EXHIBIT 1

SCHEMATIC OF WORK PROGRAM


PHASE I
PREPARATORY ACTIVITIES
PHASE II
CURRENT SERVICES INVENTORY
PHASE III
DOCUMENTATION OF NEEDS
PHASE IV
ANALYSIS, CONSOLIDATION AND CONFIRMATION OF THE TOTAL DATA BASE
PHASE V
MODEL DEVELOPMENT
PHASE VI
COMMUNITY TESTING AND BUILDING ACCEPTANCE
PHASE VII
FINAL RECOMMENDATIONS AND IMPLEMENTATION PLAN
Elapsed Time in Months
1
4
5
6
8
9
Steering Committee Meetings

- the planning and conduct of 7 public consultations in January, 1986 which were open to the public to discuss concerns and issues pertaining to mental health and to promote interest in the study (also included in Appendix C);
- a review of current trends and models in mental health service delivery and management;
- preparation of the model for mental health services;
- a second set of consultations in each service area of the Northeast to test the proposed model with 14 selected groups of providers and key influencers (included in Appendix C); and
- preparation of an implementation plan with timeframes, staffing, cost estimates, and retraining and redeployment issues.

Between September 1985 and August 1986 the Steering Committee spent between two to three weeks in meetings to prepare the plan which appears in this report.

IV. OVERVIEW OF NORTHEAST ONTARIO

Throughout this study the Steering Committee was asked to consider numerous data about the Northeast catchment area and the current strengths and weaknesses of existing services, in order to draw conclusions and set the scene for model development. As discussed in Section III, Work Program, the Consultants undertook major data collection activities and analysis, utilizing a variety of available resources through interviews, questionnaires and public consultations.

The areas considered as part of Northeast Ontario are Algoma, Cochrane, Timiskaming, Nipissing, Manitoulin and Sudbury. The original scope of the study included Parry Sound as part of Northeast Ontario. It is recognized that the NBPH provides psychiatry services for the northern "bush" area and eastern corridor of Parry Sound and that 18% of admissions are from this area. As well, Parry Sound children are referred to the Sudbury Algoma Hospital for care. Some of the data presented thus includes some information on the area.

However, during the study, the Committee made the decision that recommendations would not be made on a specific model for Parry Sound for three reasons. First, and perhaps most important, was that there were no members on the Steering Committee from the Parry Sound area. Secondly, the Parry Sound catchment area is split in the sense of regional referral patterns, with many providers referring patients to the Penetanguishene Psychiatric Hospital for care. Including Parry Sound as part of the Northeast would require a change in referral practices.

Thirdly, Parry Sound was not included because the area is in the process of organizing formally with Muskoka to establish a District Health Council. The total population of the combined areas is about 80,000 which is sufficient size to consider for a model similar to that proposed for the four service areas. The implications and specific recommendations to the Ministry on dealing with Parry Sound are discussed in the section on model applications.

A summary of findings and conclusions arising out of this phase of activity are discussed as follows:

- demographic characteristics;
- expenditures on mental health;
- utilization review of hospital services;
- questionnaire and interview findings; and
- summary conclusions.

DEMOGRAPHIC CHARACTERISTICS

This sub-section presents demographic highlights for the Northeast region. The unique demographic characteristics of the four service areas are discussed in the section on model applications, especially with respect to issues of access to mental health services and the needs of francophones and native groups.

Introduction

As shown in Exhibit 2, the Northeast covers a vast land area of 277,103 square kilometers, representing 30% of the Province of Ontario. With a population of 549,832 in 1981, the Northeast represents only 6.4% of the total Ontario population. These two factors result in a low population density of 2.0 residents per square kilometer compared to the Ontario average of 9.4. For planning purposes it is important to recognize that 74% of Northeast residents live in an urban centre, while 26% are in rural settings.

Population Projections

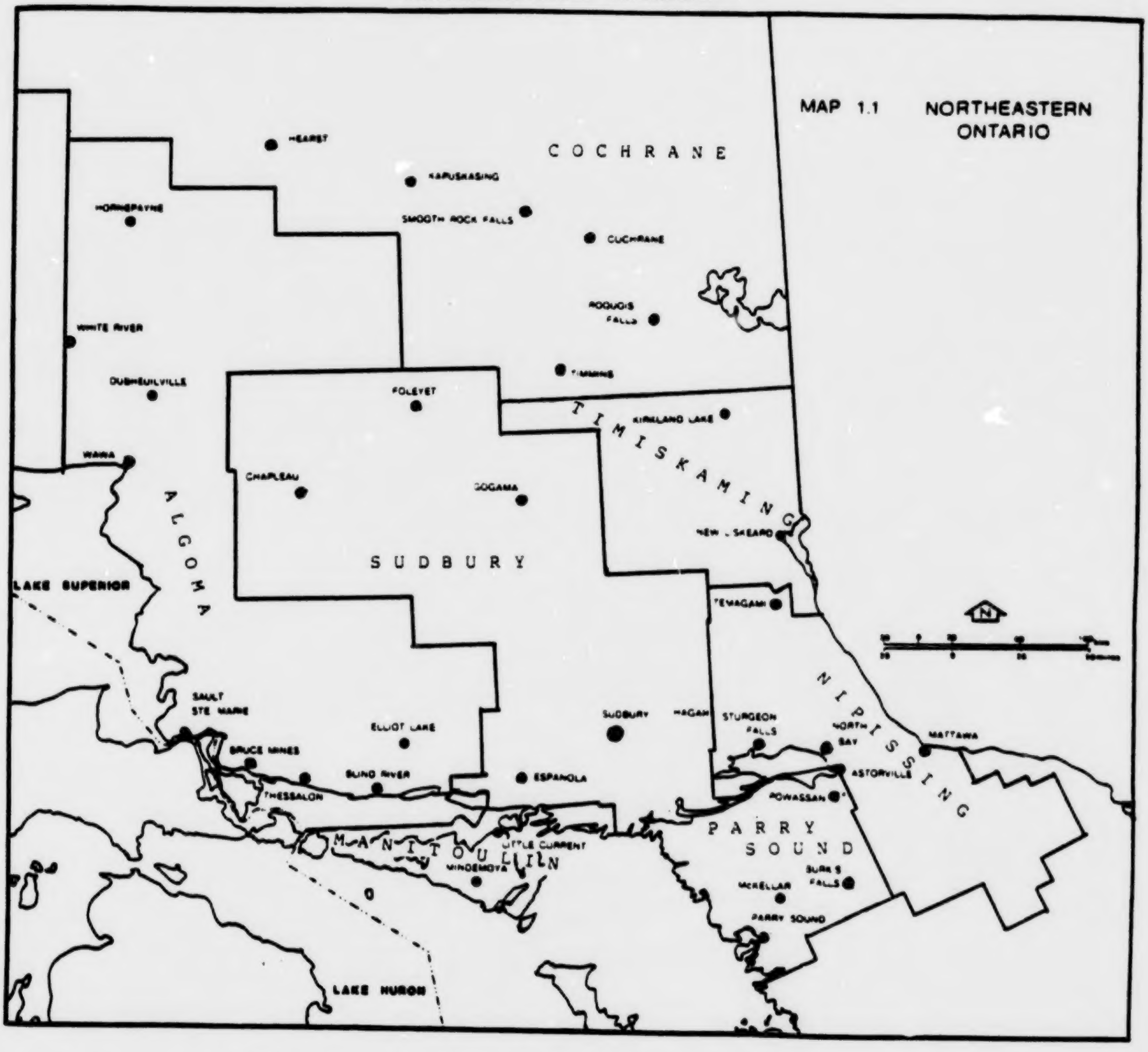
The proposed model for mental health services is to include a system for year 2000, and beyond. Therefore, it is necessary to examine population projections for Northeast Ontario and the four service areas. Age specific projections are included in Appendix E. The projections used in this study are based on the August, 1985 updates to the census by the Ministry of Treasury and Economics. A medium migration/medium fertility scenario is applied, indicating that the Northeast population is not expected to grow significantly over the 1981 to 2001 period. A small increase of 6.2% is projected in light of a change in population from 549,610 to 583,616. This increase is attributed mainly to some ambitious projections for Algoma of 17% with all other areas remaining relatively stable.

The allocation of population across the areas is discussed in more detail in the section related to model applications in the service areas; however, projections indicate that in 2001, the Northeast population will be distributed as follows:

Service Area	Population	Percentage of Total
Manitoulin/Sudbury	200,010	34.3
Algoma	155,759	26.7
Nipissing/Timiskaming	121,178	20.8
Cochrane	106,669	18.2
Total Northeast	583,616	100.0

EXHIBIT 2

NORTHEASTERN ONTARIO


MAP 1.1
NORTHEASTERN ONTARIO
COCHRANE
HEARST
KAPUSKASING
HORNEPAYNE
SMOOTH ROCK FALLS
COCHRANE
ROQUOIS FALLS
WHITE RIVER
DUBREUILVILLE
TIMMINS
FOLEYET
KIRKLAND LAKE
TIMISKAMING
WAWA
CHAPLEAU
GOGAMA
ALGOMA
NEW LISKEARD
SUDBURY
LAKE SUPERIOR
TEMAGAMI
N
NIPISSING
SAULT STE MARIE
ELLIOT LAKE
SUDBURY
HAGAR
STURGEON FALLS
NORTH BAY
MATTAWA
BRUCE MINES
BLIND RIVER
ESPANOLA
ASTORVILLE
THESSALON
POWASSAN
MANITOULIN
LITTLE CURRENT
MINDEMOYA
PARRY SOUND
BURK'S FALLS
McKELLAR
PARRY SOUND
LAKE HURON

EXCERPT: THE 1981 NORTHEAST MENTAL HEALTH STUDY

Age Mix

In terms of mix, 1986 estimates show Northeast Ontario to be slightly younger than the average for Ontario:

	Ontario % Mix	Northeast Ontario % Mix
0-14	20.5	22.8
15-19	7.6	8.5
20-24	9.1	10.5
25-34	17.2	16.5
35-44	14.4	13.2
45-64	20.2	19.3
65+	11.0	9.2

However, the trend towards a more aged population is projected for Northeast Ontario, similar to that expected in Ontario. By 2001, almost 71,000 or 12.1% of residents will be over 65, still slightly behind the Ontario expected average of 13.9%.

Mother Tongue

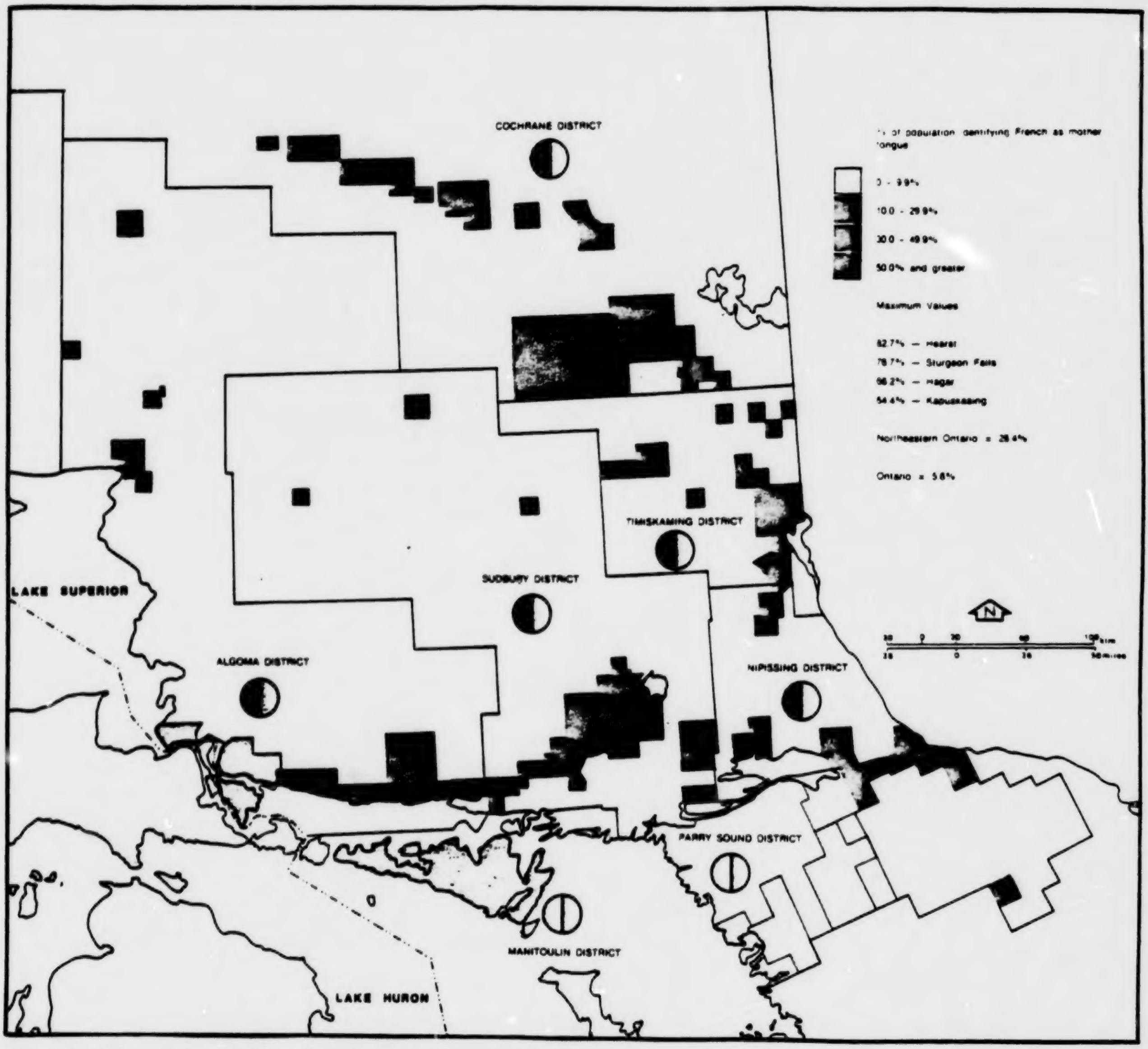
Data on mother tongue for the Northeast indicates that 90% of residents report one of the two official languages as their mother tongue, as follows:

- 63% english;
- 27% french; and
- 10% other.

The "other" mother tongue category captures many of the Italian, Finnish and native communities in the North. Most notable, however, is the high percentage of francophones, 27% in the Northeast, compared to the 5.5% average reported for Ontario. In fact, almost 32% of Ontario francophones reside in the Northeast. The 1981 Northeast Mental Health Study performed extensive analysis of census districts to identify distributions of francophone groups. While based on 1976 census data, it is not expected that the general distribution of francophones would have changed significantly from the scenario shown in Exhibit 3, and is therefore presented for additional information. As shown, language and cultural characteristics vary significantly across the Northeast, noting that Cochrane, Nipissing, Timiskaming and Sudbury have areas with large concentrations of francophones. Algoma and Manitoulin have primarily anglophone populations.

EXHIBIT 3

MAP 4.4 DISTRIBUTION OF FRANCOPHONE POPULATION


COCHRANE DISTRICT
TIMISKAMING DISTRICT
SUDBURY DISTRICT
ALGOMA DISTRICT
NIPISSING DISTRICT
PARRY SOUND DISTRICT
MANITOULIN DISTRICT
LAKE SUPERIOR
LAKE HURON
% of population identifying French as mother tongue
0 - 9.9%
10.0 - 29.9%
30.0 - 49.9%
50.0% and greater
Maximum Values
82.7% — Hearst
78.7% — Sturgeon Falls
66.2% — Hagar
54.4% — Kapuskasing
Northeastern Ontario = 28.4%
Ontario = 5.8%
N
20 0 20 60 100 km
25 0 25 50 miles

EXCERPT: THE 1981 NORTHEAST MENTAL HEALTH STUDY

Native Peoples

There are 25 native reserves in the Northeast; however, it should be noted that census data does not separate out the significant number of native persons living in areas/cities outside reserves. There were 8,634 residents living on reserves at the time of the 1981 census. The majority of this population or 41% live in the Sudbury and Manitoulin areas. The remaining population is distributed with 26% in Algoma, 23% in Cochrane and 10% in Nipissing and Timiskaming.

Labour Force Activity/Income

Statistics on labour force activity in the Northeast reveal lower than average employment and income compared to the provincial average as follows:

	Participation Rate (%)	
	Ontario	Northeast Ontario
Males 15 and over	79.8	75.8
Females 15 and over	55.2	46.4

The participation rate for females is most notably lower, almost 10% behind the provincial average of 55.2%. Similarly, wages in the Northeast are 4.4% lower for men and almost 18% lower for women (supporting detail appears in Appendix E).

Family Data

Family data indicates that there are 141,925 families in the Northeast of which almost 89% are husband/wife families and 11.4% are single parent lead. The average number of persons per household of 3.0 is relatively constant across the Northeast. As well, an average 1.5 children per family is fairly constant but slightly higher than the 1.3 reported for the Province.

Education

Educational levels are significantly lower in the Northeast than the Provincial average with 22.3% of residents over the age of 15 having less than Grade 9 schooling. This is 5% higher than the 17.2% average for Ontario.

EXPENDITURES ON MENTAL HEALTH

The background piece to this study included a discussion of the trend towards more community-based services and recognized the Ontario Ministry of Health's commitment to introduce a more balanced system of care. Policy and commitments by the Government set the direction for the investment of financial resources. It is informative to review the provincial expenditures on mental health, including more notable trends in spending over recent years and then examine the Northeast expenditures.

Ontario Mental Health Expenditures

The most recent information on provincial mental health spending shows that the Ontario Ministry of Health spent an estimated $783.0 million on mental health activities in 1983/84. This represents an increase of $73.5 million or 10.35% over the prior fiscal year. The following graph, Exhibit 4 shows the estimated expenditures by program area.

As shown, psychiatric hospitals received $296.2 million from the Ministry of Health for fiscal year 1983/84, which was the largest share of expenditure on mental health services and approximately 37.8% of the total. This category is followed by expenditures for psychiatric patients in general hospitals of $171.0 million or 21.8% of the total. The third largest expenditure was on OHIP payments, designated by physicians as mental health services, of $157.6 million or 20.1% of the total. The above three programs together accounted for approximately 80% of the estimated total mental health expenditures.

Exhibit 5 summarizes the expenditures and percentage changes over the prior fiscal year for the three fiscal years, 1981/82, 1982/83 and 1983/84. Total expenditures increased 27.3% over the two year period with the greatest increases noted for community mental health, 69.4%, and alcohol and drug programs, 66.7%. These trends illustrate Ministry of Health commitment towards more community-based services and the relatively new area of addictions programs.

One notes annual percentage increases of 10.35 to 15.37 for mental health service over the period and that per capita spending on mental health has increased almost 25% in the two years.

Northeast Ontario Mental Health Expenditures

Northeast Ontario represents 6.4% of the population of Ontario and it receives 6.1% of the total mental health payments, e.g., an estimated $47.6 million annually. As shown below, it is estimated that the region receives 20.8% of the province's local health agency funding and 10.3% of the provincial expenditures on alcohol and drug programs. The Northeast, however, receives only 1.8% of total mental health-related OHIP payments.

EXHIBIT 4

ESTIMATED MENTAL HEALTH EXPENDITURES
FISCAL YEAR 1983/84

```
MENTAL
HEALTH
PROGRAM

          |
PSY HOSP  |****************************************************
GEN HOSP  |******************************
OHIP      |****************************
HSC       |***************
CMH       |******
ASSOC     |*****
ALCOHOL   |*
LOCAL     |*
CLINICAL  |*
RES DEV   |
          |______*______*______*_______*_______*_______*_______*___
                40000  80000  120000  160000  200000  240000  280000

                       EXPENDITURE ($ '000)
```

Source: Ontario Ministry of Health

EXHIBIT 5

SUMMARY OF ESTIMATED ONTARIO EXPENDITURES ON MENTAL HEALTH SERVICES BY PROGRAM, FISCAL YEAR 1981/82 to 1983/84

	1981/82	1982/83	1983/84	% Increase
OHIP Payments				
Expenditures ($)	108,535,068	137,826,980	157,573,589	45.2
Percentage Change (%)	25.54	26.99	14.33	
Per Capita ($)	12.58	15.81	17.87	
Community Mental Health				
Expenditures ($)	17,753,728	23,456,974	30,068,268	69.4
Percentage Change (%)	30.15	32.12	28.18	
Per Capita ($)	2.06	2.69	3.41	
Alcohol & Drug Programs				
Expenditures ($)	4,096,906	5,191,643	6,828,974	66.7
Percentage Change (%)	10.72	26.73	31.54	
Per Capita ($)	0.47	0.60	0.77	
Psychiatric Hospitals				
Expenditures ($)	232,094,363	272,638,406	296,215,839	27.6
Percentage Change (%)	10.96	17.47	8.65	
Per Capita ($)	26.91	31.28	33.59	
General Hosptials				
Expenditures ($)	147,777,662	155,022,991	170,960,701	15.7
Percentage Change (%)	13.48	4.91	10.28	
Per Capita ($)	17.13	17.79	19.39	
Homes for Special Care				
Expenditures ($)	74,608,187	82,045,759	85,391,279	14.5
Percentage Change (%)	11.31	9.97	4.08	
Per Capita ($)	8.65	9.41	9.68	
Local Health Agencies				
Expenditures ($)	3,801,054	4,165,548	4,828,254	27.0
Percentage Change (%)	0.00	9.59	15.91	
Per Capita ($)	0.44	0.48	0.55	
Grants to Associations				
Expenditures ($)	22,258,068	24,688,010	26,311,647	18.2
Percentage Change (%)	12.31	10.92	6.58	
Per Capita ($)	2.58	2.83	2.98	
Research Grants				
Expenditures ($)	3,908,176	4,365,900	4,704,500	20.4
Percentage Change (%)	8.65	11.72	7.76	
Per Capita ($)	0.45	0.50	0.53	
Health Resource Development				
Expenditures ($)	110,360	168,875	145,478	31.8
Percentage Change (%)	(81.39)	53.03	(13.85)	
Per Capita ($)	0.01	0.02	0.02	
TOTAL				
Expenditures ($)	614,943,572	709,571,086	783,028,529	27.3
Percentage Change (%)	14.30	15.39	10.35	
Per Capita ($)	71.30	81.41	88.80	25.0

Sosurce: Ontario Ministry of Health

The overall Northeast Ontario share of the provincial total in 1983/84 was as follows:

	Northeast (% of Total Provincial Expenditures)
Local Health Programs	20.8%
Alcohol & Drug Programs	10.3
Homes for Special Care	8.3
Community Mental Health	8.0
Psychiatric Hospitals	7.2
Grants to Associations	6.8
Research Grants	6.4
General Hospitals	6.0
OHIP Payments	1.8
Share of Total Provincial Funds	6.1
Share of Population	6.4

The mix of mental health funding for the Northeast region can also be compared to the provincial mix as follows.

	% Mix of Total Expenditures	
Category	N.E.	Province
Psychiatric Hospital	44.5	37.8
General Hospital	21.4	21.8
OHIP	6.1	20.1
Homes for Special Care	14.9	10.9
Community Mental Health	5.0	3.8
Alcohol & Drugs	1.5	0.9
Other	6.6	4.7
	100.0	100.0

The low percentage of funding through OHIP payments illustrates a relative shortage in claims submitted by doctors related to a psychiatric diagnosis. Furthermore, the number of physician mental health services declined over the period of 1982/83 to 1983/84, from 105,158 to 99,380 respectively.

The low percentile of funding for mental health services from OHIP payments raises questions of whether there are fewer general practitioners in Northeastern Ontario, or general practitioners are under-utilized in mental health service delivery or general practitioners are not recognizing or classifying patients in mental health diagnostic groups. This finding is consistent with the results of the general practitioners questionnaire, where 55% of physicians reported that 25% or less of the treatments were for mental health services.

However, the current 435 general practitioners for a population of 550,000 and an average practice size of 1,200 to 1,300 appears very reasonable overall and would not support the idea that billings are low due to a shortage in doctors.

As shown in the mix of expenditures, the Northeast has made a significant investment in institutional care, with 66% of total mental health expenditures for the psychiatric hospital and other designated general hospital psychiatric services. This is higher than the provincial average of 59.6%. This traditional reliance on hospital-based mental health services in the Northeast poses a challenge in establishing a system for the year 2000 which requires a shift in dollars and priorities, and enhanced responsibilities of the general practitioner and primary care workers.

UTILIZATION REVIEW OF HOSPITAL SERVICES

The Northeast Region has a total of 465 adult psychiatry beds and 32 child and adolescent beds within five designated psychiatry services:

	Beds
North Bay Psychiatric Hospital	308
Sudbury Algoma Hospital	97*
Sudbury General Hospital	36
Plummer Memorial Hospital	36
St. Mary's Hospital	20
Total Psychiatry Beds	497

Of total separations in the Region, 60% are handled by these five designated service providers, representing almost 86% of psychiatric patient days. Community hospitals are also recognized as playing a significant role in providing mental health care, e.g. handling the other 40% of admissions/ separations and 15% of patient days. A ranking of hospitals by level of activity (e.g., separations and patient days) appears in Exhibit 6.

For the purposes of this review, 1984/85 HMRI data were obtained from the Ministry of Health Data Development Branch for all hospitals in Northeast Ontario. The five designated

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* Includes 32 children's beds.

EXHIBIT 6

Top Fifteen
Northeastern Ontario Hospitals
Treating Mental Health Illness
(1984/85)

Ranked According to Number of Psych Separations		Cumulative %
1. Sudbury Algoma	1,015	15.2
2. North Bay Psychiatric	844	27.9
3. Plummer Memorial	781	39.6
4. Sudbury General	701	50.2
5. St. Mary's General	596	59.1
6. Kapuskasing-Sensenbrenner	269	
7. New Liskeard	265	
8. Lady Minto	183	
9. Kirkland District	173	
10. Elliot Lake St. Joseph's	169	
11. North Bay Civic	161	
12. Parry Sound District	133	
13. Blind River	117	
14. North Bay St. Joseph's	110	
15. Hearst Notre Dame	93	
16. West Nipissing	93	
Other	956	
TOTAL	6,659	

Ranked According to Number of Psych Patient Days		Cumulative %
1. North Bay Psychiatric	84,379	52.3
2. Sudbury Algoma	18,895	64.0
3. Plummer Memorial	12,454	71.7
4. Sudbury General	11,409	78.8
5. St. Mary's General	9,981	85.0
6. Kapuskasing-Sensenbrenner	2,406	
7. New Liskeard	2,189	
8. Kirkland District	2,069	
9. North Bay Civic	1,956	
10. Lady Minto	1,236	
11. Parry Sound District	1,155	
12. Elliot Lake St. Joseph's	1,151	
13. North Bay St. Joseph's	1,134	
14. Hearst Notre Dame	960	
15. West Nipissing	864	
Other	9,090	
TOTAL	161,328	

Source: Ontario Ministry of Health Data Development Branch

services are presented in the next sections with specific utilization information on their psychiatry services. Following this is a discussion of other utilization and waiting list information.

North Bay Psychiatric Hospital (NBPH)

This facility is owned and operated by the Ontario Ministry of Health and its general purpose is to service the region with the following services by bed size and target area:

Service	Beds	Focus
Acute admissions	26	local
Acute admissions	26	regional
Special rehabilitation	130*	regional
Social adaptation	24	regional
Forensic/secure	24	regional
Psychogeriatric	78	regional
Total	308	

One unit, a 26-bed acute admission service is limited in scope to local admissions. As shown in Exhibit 6, North Bay Psychiatric Hospital (NBPH) ranks first in patient days, with 84,379 days annually and follows Sudbury Algoma Hospital in separations, with only 844 or 13% of total discharges from the Northeast hospitals. This reflects the longer average length of stay at the hospital attributed mainly to its special rehabilitation and psychogeriatric services, which provide many "chronic" types of services.

Average length of stay (ALOS) in the NBPH acute admission units is more consistent with short average length of stay evident in other acute psychiatric services, 18.5 days. The ALOS has reportedly been reduced from 26 days to the current 18.5 due to the development of the out-patient service in the city, enabling earlier discharge.

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* Utilization data shows that 18 patients have a primary diagnosis of mental retardation.

*** Referrals**

Exhibit 7 presents a patient resident profile based on psychiatric separations for the hospital, from various areas. This analysis shows where patients came from to receive treatment at NBPH during 1984/85. The major areas served by NBPH are Nipissing, representing 363 or 44% of the total separations, Cochrane with 149 or 18%, Timiskaming

with 10.8% and Parry Sound with 7.5%. Of interesting note is that while NBPH has 90% of its beds committed to a "regional" function, over 50% of separations were individuals from Nipissing or Timiskaming.

It has been suggested that one reason for this trend is the migration over the years to North Bay by the chronic ex-psychiatric patient. In fact, it has been estimated that 1 out of 2 participants at the downtown Canadian Mental Health Association drop-in centre is "originally from an area outside Nipissing".

*** Diagnostic Groups**

NBPH has a role to provide adult psychiatric services only; however in 1984/85, 57 adolescents, aged 15 to 19 were discharged. This represented almost 7% of total separations as shown in Exhibit 8.

Psychotic separations accounted for 54.9% of total separations at NBPH in that it treats a high percentage of schizophrenic patients, 32.1% affective psychosis, 11.8% and personality disorders, 11.7%. These groups represent many of the "chronic" users of mental health services to be considered in model development.

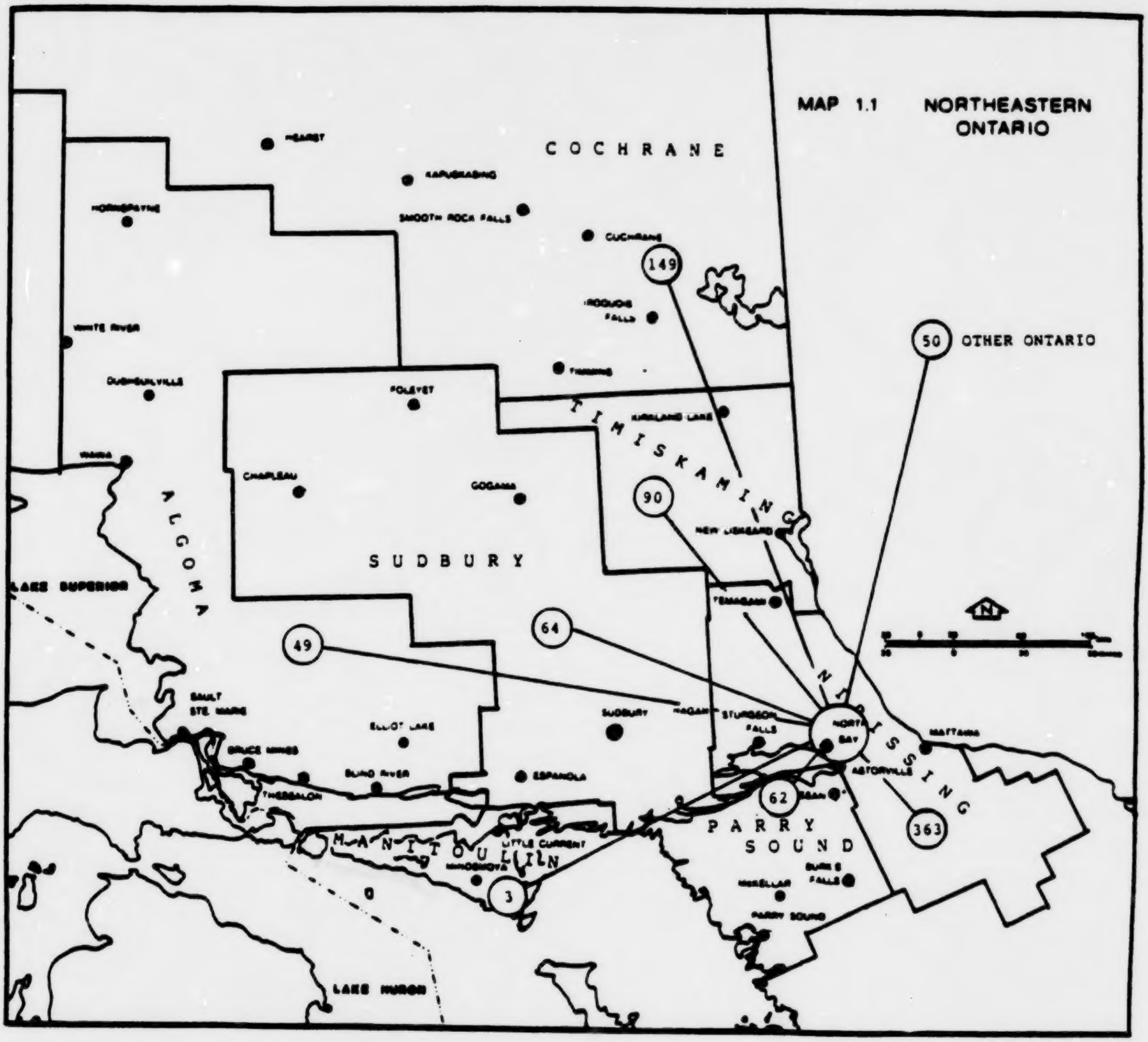
The hospital also reports high occupancy rates in its special rehabilitation, psychogeriatric and forensic services.

*** One-Day Snapshot**

As part of the utilization review, NBPH conducted a review of their current patient population during the first week of February 1986. Information was collected for each hospital ward and by patient, related to sex, age, primary diagnosis, length of stay, number of admission and prognosis: e.g., what

EXHIBIT 7

PSYCHIATRIC SEPARATIONS FROM NBPH
BY PATIENT RESIDENCE (1984/85)


MAP 1.1
NORTHEASTERN ONTARIO
COCHRANE
TIMISKAMING
SUDBURY
ALGOMA
NIPISSING
PARRY SOUND
MANITOULIN
LAKE SUPERIOR
LAKE HURON
HEARST
KAPUSKASING
HORNEPAYNE
SMOOTH ROCK FALLS
COCHRANE
IROQUOIS FALLS
TIMMINS
WHITE RIVER
DUBREUILVILLE
FOLEYET
KIRKLAND LAKE
WAWA
CHAPLEAU
GOGAMA
NEW LISKEARD
TEMAGAMI
SAULT STE MARIE
ELLIOT LAKE
SUDBURY
STURGEON FALLS
NORTH BAY
MATTAWA
ASTORVILLE
BRUCE MINES
BLIND RIVER
ESPANOLA
THESSALON
LITTLE CURRENT
MINDEMOYA
McKELLAR
BURK'S FALLS
PARRY SOUND
149
90
64
49
62
3
363
50
OTHER ONTARIO
N

SOURCE: ONTARIO MINISTRY OF HEALTH DATA DEVELOPMENT BRANCH

NOTE: TOTALS DIFFER SLIGHTLY FROM THOSE SHOWN IN EXHIBIT 8.

EXHIBIT 8

North Bay Psychiatric Hospital
Separations by Diagnosis, Age and Sex
(1984/85)

	Ages 0-14		Ages 15-19		Ages 20-24		Ages 45-64		Ages 65+		Total Groups			%
Category	M	F	M	F	M	F	M	F	M	F	M	F	Total	Mix
Senile and Pre-Senile Dementia	0	0	1	0	1	0	3	1	12	6	17	7	24	2.8
Alcoholic Psychoses	0	0	0	0	1	0	2	3	1	1	4	4	8	0.9
Drug Psychoses	0	0	1	0	9	1	1	0	0	0	11	1	12	1.4
Other Organic Psychoses	0	0	0	0	3	4	3	2	0	1	6	7	13	1.5
Schizophrenia	0	0	19	1	134	57	28	23	4	6	185	87	272	32.2
Affective Psychoses	0	0	0	3	22	16	14	34	2	9	38	62	100	11.8
Paranoid States	0	0	0	0	4	4	3	3	3	1	10	8	18	2.1
Other Non-Organic Psychoses	0	0	2	0	9	2	0	2	1	0	12	4	16	1.9
Neurotic Disorders	0	0	0	1	20	22	8	11	1	1	29	35	64	7.6
Personality Disorders	0	0	8	1	44	34	4	4	2	1	58	40	98	11.6
Alcoholism	0	0	4	0	29	4	6	7	2	0	41	11	52	6.2
Drug Dependence and Abuse	0	0	2	1	31	11	1	3	1	0	35	15	50	5.9
Acute Reaction to Stress	0	0	0	0	1	0	1	1	1	0	3	1	4	0.5
Adjustment Reaction	0	0	2	4	15	11	8	2	0	1	25	18	43	5.1
Emotional Disturbance of Childhood and Adolescence	0	0	0	2	0	0	0	0	0	0	0	2	2	0.2
Other Non-Psychotic Disorders	0	0	2	2	9	2	5	4	5	1	21	9	30	3.6
Hyperkinetic Syndrome of Childhood	0	0	0	0	0	1	0	0	0	0	0	1	1	0.1
Specific Delays in Development	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Mental Retardation	0	0	1	0	8	8	5	7	1	0	15	15	30	3.6
Observation	0	0	0	0	3	1	0	2	1	0	4	3	7	0.8
TOTAL	0	0	42	15	343	178	92	109	37	28	514	330	844	100.0

Source: Ontario Ministry of Health Data Development Branch

is the discharge/accommodation plan for the patient in the future according to these scenarios:

- discharge directly into the community;
- discharge to a supportive housing situation;
- discharge to a nursing home/home for the aged; and
- continued hospitalization required.

Of the 202 patients, (excluding geriatric patients) in the hospital, 105 patients or 52.0% of the total were considered by staff to require continued hospitalization.

Fifty-five or 27.2% of the patients were candidates for placement in supervised homes, 33 or 16.3% would likely be directly discharged, and 4.5% could be discharged to nursing homes.

Of the 72 psychogeriatric patients on three wards, 70% were considered to require on-going care in an institutional/hospital setting.

Supporting detail for the One-day Snapshot is contained in Exhibit 9.

On the day of the utilization snapshot the following occupancy levels were identified:

	Occupancy
Acute Admissions	63%
Special Rehabilitation	98%
Social Adaptation Program	71%
Forensic	100%
Psychogeriatrics	92%

Sudbury Algoma Hospital (SAH)

The Sudbury Algoma Hospital (SAH) is a 97-bed psychiatry facility in Sudbury. Of these beds, 65 are used for adult psychiatry, which serve Manitoulin/Sudbury and are funded by the Ministry of Health. As well, the hospital is funded for 19 detox beds and a variety of community-based mental health programs. In 1984/85 SAH reported 1,015 separations and 18,895 patient days for its services.

EXHIBIT 9

North Bay Psychiatric Hosptial
Patients On The Books: Future Plans for Accommodation or Placement
February, 1986

Unit		Total Patients	Direct Discharge	Nursing Home, HFA	Supervised Home Placement	Continued Hospitalization
1A	Special Services	24	4	3	13	4
1C	Admission	15	10	1	3	1
1D	Acute Admission	18	10	1	4	3
2A	Special Services Rehabilitation	26	-	2	17	7
2B	Special Services Rehabilitation	26	-	-	3	23
2C	Special Services	26		1	3	22
2D	Special Services	26	-	-	-	26
4B	Special Services	17	8	1	8	-
4D	Forensic	24	1	-	4	19
	Sub-total (general psychiatry)	202	33	9	55	105
	% OF TOTAL (202)		16.3	4.5	27.2	52.0

Unit						
3A	Psychogeriatrics	25	-	11	1	13
3B	Psychogeriatrics	25	-	-	-	25
3D	Psychogeriatrics	22	1	8	1	12
	Sub-total (psychogeriatric)	72	1	19	2	50
	% of Total (72)		1.4	26.4	2.8	69.4
	TOTAL HOSPITAL	274	34	28	57	155
	%		12.4	10.2	20.8	56.6

Source: North Bay Psychiatric Hospital records

*** Adult Services**

The adult in-patient service reported 8,354 patient days in 1984/85. Occupancy in this year was 79% and the average length of stay was 18 days. There are no waiting lists for adult in-patient services.

As further illustrated in Exhibit 10 the SAH treats a broad mix of adult diagnostic groups - with the chronic disorders such as schizophrenic, affective psychosis and personality disorders representing over 40% of separations. This is followed by a high number (178) of separations for addictions treatment - representing 19% of the total.

*** Regional Children's Services**

The SAH 32-bed children's service is regional in scope, responsible for all of Northeast Ontario and beyond. The regional service is funded by the Ministry of Community and Social Services. As shown in Exhibit 10 there were 100 separations of children and adolescents from the SAH in 1984/85. This represents only a small percentage, under 10% of total separations from the hospital of 1,015. The children's in-patient service represented 10,541 patient days in 1984/85. The service maintains a 90 to 95% occupancy rate and children may wait up to a month for a bed.

A month is considered to be an extensive waiting time for a child requiring acute intervention. The result is that many children's mental health centres have generally stopped referring to the Sudbury Algoma service, and often rely on alternative treatment methods in their own area. Such approaches have included using general paediatric beds for an acute admission with extensive involvement of children's mental health centre professionals in the treatment of the child. In some cases the child may remain at home but have daily contact with the children's mental health centre in an attempt to prevent acute admission.

Children's professionals suggest that a significant improvement in the children's mental health system could be made if beds were made available in each service area.

For children, "emotional disturbances" or "other non-psychotic disorders" account for 56% of separations. This category precedes schizophrenia

Sudbury Algoma Hospital
Separations by Diagnosis, Age and Sex
(1984/85)

	Regional Role							Acute Care Beds for Manitoulin/Sudbury									SAH Total		
	Ages 0-14		Ages 15-19		Total			Ages 20-24		Ages 45-64		Ages 65+		Total					
Category	M	F	M	F	M	F	Total	M	F	M	F	M	F	M	F	Total	M	F	Total
Senile and Pre-Senile Dementia	0	0	0	0	0	0	0	1	0	2	4	7	5	10	9	19	10	9	19
Alcoholic Psychoses	0	0	1	0	1	0	1	1	0	5	2	2	0	8	2	10	9	2	11
Drug Psychoses	0	0	3	0	3	0	3	5	0	0	1	0	0	5	1	6	8	1	9
Other Organic Psychoses	0	0	0	0	0	0	0	2	2	2	2	5	1	9	5	14	9	5	14
Schizophrenia	0	0	7	3	7	3	10	120	42	15	26	0	1	135	69	204	142	72	214
Affective Psychoses	0	0	0	0	0	0	0	21	27	17	36	2	6	40	69	109	40	69	109
Paranoid States	0	0	0	0	0	0	0	6	3	3	2	0	2	9	7	16	9	7	16
Other Non-Organic Psychoses	0	0	2	0	2	0	2	12	7	1	2	0	0	13	9	22	15	9	24
Neurotic Disorders	0	0	3	2	3	2	5	24	66	17	25	0	15	41	106	147	44	108	152
Personality Disorders	0	0	9	1	9	1	10	49	41	2	4	1	0	52	45	97	61	46	107
Alcoholism	0	0	1	1	1	1	2	76	24	39	20	4	1	119	45	164	120	46	166
Drug Dependence and Abuse	0	0	5	0	5	0	5	8	2	1	3	0	0	9	5	14	14	5	19
Acute Reaction to Stress	0	0	2	1	2	1	3	20	25	2	6	2	1	24	33	56	26	33	59
Adjustment Reaction	0	0	2	1	2	1	3	4	11	2	5	0	2	6	18	24	8	19	27
Emotional Disturbance of Childhood and Adolescence	0	1	2	5	2	6	8	0	0	0	0	0	0	0	0	0	2	6	8
Other Non-Psychotic Disorders	1	6	18	23	19	29	48	4	0	2	1	1	0	7	1	8	26	30	56
Hyperkinetic Syndrome of Childhood	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specific Delays in Development	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Retardation	0	0	0	0	0	0	0	2	1	1	0	0	0	3	1	4	3	1	4
Observation	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	1	1
TOTAL	1	7	55	37	56	44	100	355	252	111	139	24	34	490	425	915	546	469	1015

Source: Ontario Ministry of Health Data Development Branch

EXHIBIT 10

and personality disorders which each represent another 20% of separations. Average length of stay is 99 to 100 days at SAH.

*** Referrals to the Regional Children's Services**

Exhibit 11 presents a patient resident profile based on "children's" discharges from the Sudbury Algoma hospital from various areas. Of the 103 separations in 1984/85, 47% or 48 of the total separations were from within the Sudbury and Manitoulin/Sudbury area. The remaining 55 separations were divided amongst 43 from the other areas in the Northeast and 12 from unspecified areas outside the region. This suggests that some level of regional services is being provided and that it is not just Manitoulin/Sudbury which is being served.

As discussed previously however, there are reportedly other options being used by service area providers which reduce their reliance on the SAH service and keep the child closer to home.

This qualitative input by children's mental health centres on their utilization of the SAH is important to the recommendations which are made later to enhance the number of treatment beds for children in the Northeast.

Plummer Memorial Hospital - Sault Ste. Marie

The Plummer Memorial Hospital has a 36-bed acute, adult psychiatry service as part of its general hospital services. As shown in Exhibit 6, it ranks third in separations and patient days with 781 separations and 12,454 patient days. Occupancy levels are consistently high, around 95%. The major diagnostic groups treated by the Hospital (as a percentage of total separations) in 1984/85 were:

neurotic disorders	- 21.9%
affective psychosis	- 18.4%
schizophrenia	- 16.0%
alcoholism	- 9.7%

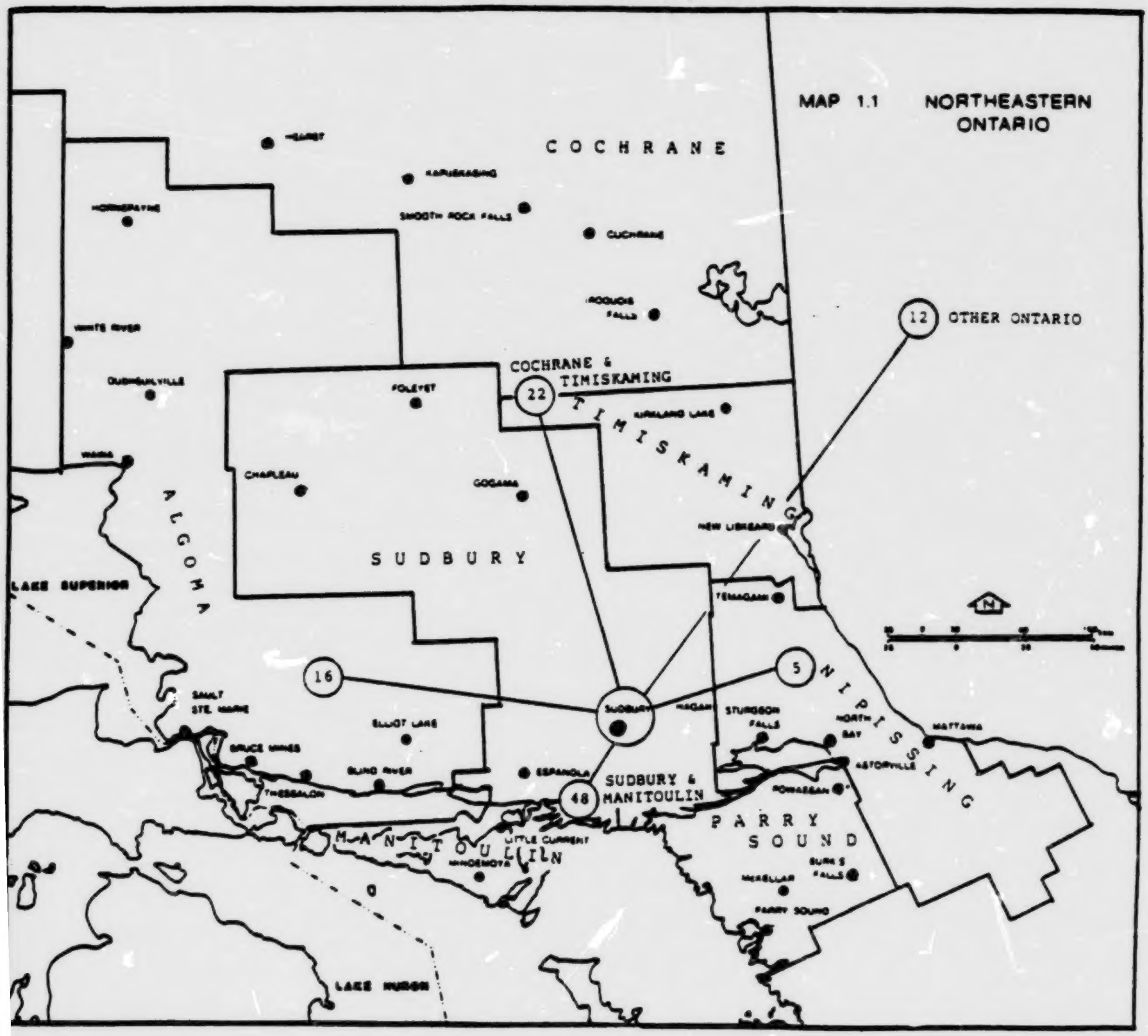
Average length of stay was slightly under 16 days.

Sudbury General Hospital

The Sudbury General has a 36-bed psychiatry service. As shown in Exhibit 6, it ranks fourth in separations and patient days with 701 separations and 11,409 days annually. Occupancy levels of 87% are generally maintained. Services are directed

EXHIBIT 11

CHILDREN'S PSYCHIATRIC SEPARATIONS FROM SAH
BY PATIENT RESIDENCE (1984/85)


MAP 1.1
NORTHEASTERN ONTARIO
COCHRANE
HEARST
KAPUSKASING
SMOOTH ROCK FALLS
COCHRANE
HORNEPAYNE
IROQUOIS FALLS
12
OTHER ONTARIO
WHITE RIVER
DUBREUILVILLE
COCHRANE & TIMISKAMING
22
FOLEYET
TIMISKAMING
KIRKLAND LAKE
WAWA
CHAPLEAU
GOGAMA
ALGOMA
NEW LISKEARD
SUDBURY
LAKE SUPERIOR
TEMAGAMI
16
5
NIPISSING
SAULT STE. MARIE
SUDBURY
HAGAR
STURGEON FALLS
NORTH BAY
MATTAWA
ELLIOT LAKE
BRUCE MINES
BLIND RIVER
ESPANOLA
ASTORVILLE
THESSALON
48
SUDBURY & MANITOULIN
POWASSAN
PARRY SOUND
MANITOULIN
LITTLE CURRENT
MINDEMOYA
BURK'S FALLS
MCKELLAR
PARRY SOUND
LAKE HURON
N

SOURCE: AS REPORTED BY SAH

towards the Manitoulin/Sudbury service area. Like the Plummer Memorial Hospital, the major diagnostic groups treated by the Sudbury General (as a percentage of total separations) in 1984/85 were:

neurotic disorders - 21.7%
affective psychosis - 20.7%
schizophrenia - 12.0%

Average length of stay was 16 days.

St. Mary's General Hospital - Timmins

The St. Mary's General Hospital in Timmins has a 20-bed acute adult psychiatric service as part of its range of medical services. As shown in Exhibit 6, it ranks fifth in separations and patient days with 596 separations and 9,981 patient days. Occupancy levels well exceed capacity, on average, requiring 25 to 30 beds for patients with a psychiatric diagnosis.

The major diagnostic groups treated by the Hospital (as a percentage of total separations) in 1984/85 again reflect a similar mix as the Plummer Memorial and Sudbury General Hospitals:

neurotic disorders - 32.9%
alcoholism - 13.8%
affective psychosis - 13.6%
schizophrenia - 12.1%

Alcoholism is higher in this mix than generally for the other hospitals.

Average length of stay was 16 to 17 days.

Other Community Hospitals

The total number of hospitals reporting psychiatric separations was 34. As shown in Exhibit 6, other community hospitals make significant contributions to acute psychiatry care. For example, based on the patient days on an average day, the following hospitals use a number of their medical/surgical beds for individuals with a psychiatric diagnosis.

	Number of Beds Used on Average*
Kapuskasing-Sensenbrenner (North Cochrane)	6-7
New Liskeard (Timiskaming)	6
Kirkland Lake (Timiskaming)	5-6
North Bay Civic	5-6
Elliot Lake - St. Joseph's (East Algoma)	3-4

These data are considered in the proposed distribution of acute psychiatry beds and the establishment of small services in the areas of North Cochrane, Timiskaming and Algoma. The reader will note that a Parry Sound Hospital appears in the listing as initially this area was to be considered.

* * * * *

Service Area Self-Sufficiency and Treatment Trends

A later section on each service area includes further details arising from this utilization review. For purposes of this review and planning for more decentralized services in the

Northeast it is important to recognize the current extent of self-sufficiency which exists within the service areas. The Steering Committee was encouraged to learn that there is already strength and activity evident in many hospitals, beyond that provided by designated psychiatry services. Exhibit 12 indicates where residents of various areas, (who were discharged during 1984/85) were treated.

Overall, 87% of Northeast residents received in-patient treatment in their area of residence. It is recognized that this data must be used carefully in light of the historic migration of the chronic patients to the North Bay area, who may have originally been referred from Algoma, Cochrane, etc. and now declare Nipissing their home.

Average length of stay data by diagnostic category generally provides some indication of treatment approach and the level of activity in mental health care. Exhibit 13 shows the analysis for the two psychiatric hospitals compared to the average length of stay within the four service area's general hospitals.

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* Number of beds used on average = [Annual patient days] 365 days

EXHIBIT 12

REGIONAL SUMMARY OF RESIDENT LOCATION OF MENTAL HEALTH TREATMENT
(Based on Number of 1984/85 Psychiatric Separations)

ALGOMA RESIDENTS TREATED:	Number of Separations	%
In Algoma	1,195	85.1
Sudbury Algoma Hospital	69	4.9
North Bay Psychiatric Hospital	49	3.5
Homewood Sanitarium	37	2.6
Other - within N.E. Ontario	44	3.1
Other - outside N.E. Ontario	10	0.8
	1,404	100.0
COCHRANE RESIDENTS TREATED:		
In Cochrane	1,367	86.1
North Bay Psychiatric Hospital	149	9.4
Homewood Sanitarium	37	2.3
Sudbury Algoma Hospital	18	1.1
Other - ouside N.E. Ontario	9	0.6
Other - within N.E. Ontario	8	0.5
	1,588	100.0
TIMISKAMING RESIDENTS TREATED:		
In Timiskaming	464	77.6
North Bay Psychiatric Hospital	90	15.1
Sudbury Algoma Hospital	7	1.2
Other - within N.E. Ontario	25	4.1
Other - outside N.E. Ontario	12	2.0
	598	100.0
NIPISSING RESIDENTS TREATED:		
In Nipissing*	741	91.5
Sudbury Algoma Hospital	26	3.2
Other - within N.E. Ontario	27	3.3
Other - outside N.E. Ontario	16	2.0
	810	100.0
MANITOULIN RESIDENTS TREATED:		
In Manitoulin	66	47.8
Sudbury Algoma Hospital	52	37.7
Homewood Sanitarium	6	4.3
North Bay Psychiatric Hospital	3	2.2
Other - within N.E. Ontario	11	8.0
	138	100.0
SUDBURY RESIDENTS TREATED:		
In Sudbury	1,669	92.6
North Bay Psychiatric Hospital	64	3.5
Homewood Sanitarium	11	0.6
Other - within N.E. Ontario	50	2.8
Other - outside N.E. Ontario	10	0.5
	1,804	100.0
PARRY SOUND RESIDENTS TREATED:		
In Parry Sound	133	56.8
North Bay Psychiatric Hospital	62	26.5
Sudbury Algoma Hospital	7	3.0
Other - within N.E. Ontario	22	9.4
Other - outside N.E. Ontario	10	4.3
	234	100.0

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* Includes North Bay Psychiatric Hospital

Source: Ministry of Health Data Development Branch

EXHIBIT 13

ALOS COMPARISION OF SELECTED DIAGNOSTIC CATEGORIES BETWEEN PSYCHIATRIC AND COMMUNITY HOSPITALS[1]

	North Bay Psychiatric	Sudbury Algoma Hospital	Nipissing/ Timiskaming	Manitoulin/ Sudbury	Cochrane	Algoma
Senile/Pre-senile Dementia	378.5	39.9	28.7	24.9	29.0	37.3
Schizophrenia	106.3	20.6	7.5	15.1	15.8	18.2
Affective Pyychoses	55.4	27.0	11.0	23.6	20.6	20.6
Neurotic Disorders	22.2	20.2	8.4	13.2	12.0	11.4
Personality Disorders	42.7	12.5	7.2	9.3	8.4	9.2
Alcoholism	48.0	19.6	7.7	9.5	6.6	7.3
Drug Dependency and Abuse	28.8	15.5	6.5	4.2	5.3	3.2
Acute Reaction to Stress	6.5	8.3	5.0	5.0	5.0	4.8
Adjustment Reaction	21.3	11.1	4.3	7.1	5.0	7.3
Other Non-Psychotic Disorders	282.5	9.5	11.1	12.0	11.6	11.8
Mental Retardation	230.3	10.4	12.8	11.3	13.3	8.8
Average	92.8	18.6	9.9	14.0	11.7	12.8

[1] For details of the Community Hospitals included in each service area, refer to Section VIII.

Source: Ontario Ministry of Health Data Development Branch

The 92.8 average length of stay shown for NBPH reflects the more "long-term" mix of its patients. Sudbury Algoma ALOS, however, would be expected to be closer to that shown for the service areas. Such data raises questions about treatment approach and programs. One example is around the diagnosis of alcoholism where 6.6 to 9.5 days stay is the average compared to the 19.6 and the 48 days reported at Sudbury Algoma and NBPH respectively. Such data should be considered as implementation of the model proceeds and evaluation systems and standards are established for programs.

Utilization of Other Community-Based Services

It should be recognized by the reader that this utilization review focuses mainly on hospital care as there is very little available information on the range of community-based programs. In this sense some programs do not keep statistics. Many have only received funding in the past 2 or 3 years and others keep statistics internally in such a way that organizational comparisons are not possible.

The area of management information systems has become a priority for the Ministry of Health, especially related to the need for standardized reporting for new programs. In light of this, the need for improved information to support decisions which will be taken by providers in each service area and by District Health Councils which must determine priorities for funding within their area is discussed in a later section.

In the following description of our questionnaire findings, some indication of utilization is provided through the analysis of referral rates and waiting lists for services.

SELECTED FINDINGS FROM INTERVIEWS AND QUESTIONNAIRE SURVEY

The intent of this study was to incorporate a broad range of opinions and perceptions for consideration by the Steering Committee. As discussed in the work program, extensive interviews and public consultations were conducted, with additional information gathered through a questionnaire sent to general practitioners, numerous providers and special interest groups.

The response rate to the questionnaire survey was good, in that 30% of the general practitioners who were sent questionnaires responded and 38% of the providers and other agencies responded. The latter group includes a number of groups less directly involved in mental-health activities, such as churches, homes for the aged and social/recreational organizations. Most of the key direct providers responded to the survey.

The following presents responses to the questions which are relevant to providing an overview of the Northeast region. Response to more specific questions, relevant to the four geographic service areas are discussed in Section VII in describing the recommended model in each area.

Strengths and Weaknesses

From the questionnaire results, public consultations and interviews of key providers in each district, there is some degree of consensus throughout the region on the overall strengths and weaknesses of current mental health services.

Two general strengths cited are the dedication of mental health providers/professionals and the range of basic mental health services currently in place in larger communities.

The main weaknesses reported are:

- lack of children's services and waiting times for services;
- lack of francophone services;
- lack of co-ordination, communication and overall planning amongst providers and between communities;
- presence of competition between current mental health services providers;
- lack of psychiatrists and other mental health professionals;
- lack of support programs, general services, housing and case management for the chronically mentally ill patients;
- lack of preventative, rehabilitative programs and services;
- lack of crisis intervention services and training requirements for community hospital staff;
- lack of public awareness and education;
- lack of services in remote areas;
- distance, isolation and geography of areas;
- need for a creative updated treatment approach; and

- disappointment with the two tertiary services which are perceived as not effectively fulfilling a "regional" tertiary care role.

Language Need/Provider Capabilities

General practitioners (GPs) indicated that approximately one-third of their patients have a mother tongue of English and one-third have French as their mother tongue. The remaining third is split equally between Native and other languages. While 100% of GPs provide service in English, only 41% provide French language services. Native services are provided by 5% of GPs and other languages are spoken by 26% of GPs.

Of other mental health providers who responded to the questionnaire, 98% provide English language services, 28% provide French language services and 2% provide Native language services.

Demographic data from Statistics Canada indicate mother tongue breakdown in Northeastern Ontario as 63% English, 27% French and 9% Other. While the 28% of GPs who provide service in French may seem reasonable for the 27% population whose mother tongue is French, it does not speak to the issue of appropriate distribution and availability of that service.

The findings clearly indicate a deficit in one of the important primary case workers' (GP's) capability to provide service to the Native population in their own language.

Referral Patterns

GPs refer primarily to hospitals and psychiatrists as reported in the questionnaire. These referrals are made for consultation, assessment and diagnosis, or for depression or counselling. Mental health agencies are not referred to as often, these being ranked third behind hospitals and psychiatrists. The Manitoulin/Sudbury area GPs refer even less often to agencies, ranked 7 out of 9. This suggests a possible lack of awareness of services provided by mental health agencies and an emphasis on traditional hospital and psychiatrist-based services.

There is a higher degree of inter-agency referral in most areas, however clients are referred primarily to hospitals even by mental health agencies and other providers. Referrals are made for treatment, counselling/guidance and general assessment. Again this points out a reliance on hospital-based services and a possible lack of awareness or shortage of other services.

Waiting Lists

Waiting lists for mental health services were reported by 61 of the 296 responding agencies to the Questionnaire. Waiting times of less than one month were reported by 44 of the 61 agencies while the remaining 17 reported waiting times over one month. The small number of agencies reporting waiting lists indicates that generally services are available in a timely manner with minimal to no waiting period. There are no waiting times for crisis services and limited waiting periods for addictions services.

Some services however, do have extensive waiting lists and times and these include children's mental health services and nursing homes.

Contact With Planning Bodies/Organizations

There are six possible mental health planning bodies/organizations which can be used as resource groups. These are:

- Canadian Mental Health Association (CMHA);
- District Health Councils (DHC);
- Social Planning Councils;
- Community Mental Health Services Board (North Bay);
- Committees of Municipal Governments; and
- Children's Services Advisory Committees.

Agencies, as indicated from those responding to the questionnaire, are somewhat autonomous with respect to what contact they have with these other groups. Overall, 76% do not have any contact with them while the remaining 24% have either occasional (16%) or regular (8%) contact. The Nipissing and Timiskaming agencies have the least amount of contact (20%) while Cochrane has the most (28%).

The District Health Councils as compared with other groups are contacted most often by all districts except Nipissing and Timiskaming where a DHC does not exist. The Children's Services Advisory Committee is contacted the most often in this area.

The responses to this question suggest that there is a significant opportunity for providers to be more involved in the planning of mental health services in the Northeast.

OVERVIEW CONCLUSIONS

There was no shortage of data to be reviewed during this study, and in planning for a system of mental health services in the North it was very important for the Steering Committee to draw the major conclusions from the data. A summary is presented below.

Demographic Characteristics

Conclusions from the demographic review are that:

- The population in the Northeast is expected to remain relatively the same over the next 15 years, a 6% increase from 1981 to 2001 is expected.
- In terms of mix, the elderly group over 65 years is expected to increase most significantly - and the number of children will decline.
- The land area in the Northeast represents 30% of total Ontario, while the population represents under 7%. The result is a significantly low density and a challenge to provide accessible services.
- Language and cultural characteristics vary significantly across the Northeast which implies the need for flexibility and responsiveness within any effective service delivery model.
- Northeastern Ontario generally has lower than average employment and educational levels, two factors which contribute to a larger population at risk for mental health problems.

Expenditures on Mental Health

- Northeastern Ontario represents 6.4% of total Ontario population and receives 6.1% of total provincial mental health payments.
- Within this region, a greater proportion of mental health expenditures is invested in institutions (65.9%) compared to the Province (59.6%).
- One of the challenges in developing a model for 2001 will be the shift in dollars from institution-based services to community-based services and enhancing the role of the primary care providers, especially GPs.

Utilization Review

- The Northeast Region has 465 adult psychiatric beds and 32 children and adolescent beds; 66% of all beds are at the North Bay Psychiatric Hospital. However, other general hospitals throughout the Northeast Region also treat patients with mental illness diagnosis. In terms of 1984/85 utilization, the following trends are noted with regard to where patients are treated:

Area	% of Separations Handled Within Area
Algoma	85
Cochrane	86
Timiskaming	78
Nipissing	91
Manitoulin	48
Sudbury	92

- It is apparent that most areas are handling the majority of their mental health admission requirements with current resources.
- Of the total separations in the region, 60% are handled by the five designated psychiatric unit providers representing 85% of total mental health patient days.
- Generally, local community hospitals tend to treat a higher mix of neurotic and non-psychotic disorders whereas the designated psychiatric units tend to treat a greater mix of schizophrenia and psychoses.
- In planning for mental health services for the Northeast, the two diagnostic groups which represent the majority of acute and chronic mental illness are schizophrenia and affective psychoses. The other mental health diagnostic groups are not readily quantifiable; therefore judgement and experience must be used in estimating requirements.
- A February, 1986 Placement survey by NBPH staff suggested that 56.6% of current patients require continued hospitalization; the remainder will be discharged to alternative care settings.

Public Consultations, Interviews and Questionnaires

While perceived weaknesses and strengths of mental health services have been detailed earlier in this section, they are repeated here to stress the importance of these findings. The strengths and weaknesses generally were similar in each service area.

The strengths were:

- the dedication of existing mental health professionals, especially in small communities; and
- the number of basic services currently existing in large communities.

The weaknesses and gaps identified out-weigh the strengths. Interviews and questionnaires consistently highlighted the following "weaknesses" in the current mental health services:

- lack of children's services and waiting times for those which exist;
- lack of francophone services;
- lack of co-ordination and planning of services and lack of communication;
- competition amongst providers;
- lack of professionals and lack of training for community hospital staff;
- lack of programs and support services for ex-psychiatric patients;
- lack of preventative services;
- lack of services in remote areas;
- lack of public awareness and education;
- distance, isolation and geography of areas;
- disappointment with existing regional services.

V. TRENDS IN MENTAL HEALTH CARE

The Steering Committee spent some time reviewing recent trends in mental health care in North America and other parts of the world. This was essestial in order for the Committee to ensure that the Northeast model was based on the most current thinking and approaches.

- the prevailing lack of a clear definition of "mental illness" and potential scope of the problem;
- the requirement to prioritize needs in order to use scarce resources effectively - focus on individuals with chronic psychiatric needs;
- the importance of primary care providers (gatekeepers) and good case management;
- the need for a balanced system of care;
- the need for management and control mechanisms; and
- the philosophy of humane deinstitutionalization and community-based supports.

As the Steering Committee was interested in building upon past studies and accepted philosophies of the Ontario Ministry of Health, the reader will note frequent reference to the 1983 report by Dr. G.F. Heseltine which has been identified as a leader for mental health trends in Ontario.

LACK OF DEFINITION

As discussed in the 1983 Towards a Blueprint for Change authored by G.F. Heseltine:

> "there is no universally accepted definition of mental illness. It is a generic term used to characterize a broad range of behaviours and mental postures".

To this end, studies of the general population and their requirements for mental health services have provided some indication of the potential scope of mental health problems. Dr. Heseltine's report estimated that:

- one out of every seven individuals will seek assistance for a mental health problem during their lifetime; and

- at any given time, 15 to 25% of the population requires some form of mental health care.

The implied needs of the general population under the above scenarios might be infinite, thus necessitating a strategy to identify those with greatest need for the mental health system.

PRIORITIZATION OF NEEDS

One popular model, developed in 1979 in British Columbia and authored by Cummings made an attempt to prioritize mental health needs of the total population. The result is a categorization of individuals seeking mental health services by type and severity of mental illness. Categories under this model were ranked in descending order of seriousness as follows:

"1. the disabled (e.g. chronic psychotic individuals)

2. the diseased (e.g. acute psychotic individuals)

3. the distressed (e.g. neurotic individuals)

4. the dissatisfied (e.g. the bored and alienated, neither disabled or ill but may be seeking mental health services)."

For purposes of this study, primary focus is given to the disabled and the diseased with the recognition that it is these groups who consume the greatest portion of available mental health resources. It has been suggested that while such users may be small in number (a few thousand in the Northeast), they use 80% of the dollars spent on mental health due to their ongoing and predictable needs for supportive care (e.g., there is no cure as yet for such disorders).

Major Users

Two diagnostic groups have been identified throughout the research which represent the majority of acute and chronic mental health users in the population. In developing a model of service, the needs of these two groups must be considered priorities. For purposes of Northeast Ontario model development a computer simulation was used to arrive at projected age specific incidence rates and estimated numbers of individuals in these categories. The resulting standard, used in this study is 5 chronic psychiatric individuals per 1,000 general population. This number was adjusted slightly to 6.25 individuals per 1,000 population to reflect additional types of individuals (severe personality disorders, neuroses and other mental illness which have not been studied to the extent of the two major user groups). Such groups are difficult to quantify, but are considered to benefit from good case management and would naturally use mental health services.

The application of this standard in Northeast Ontario reveals the following number and potential distribution (i.e., 2001) of the major user groups (i.e., chronically mentally ill) by service area.

Service Area	Chronic Psychiatric Individuals
Manitoulin/Sudbury	1,255
Algoma	975
Nipissing/Timiskaming	757
Cochrane	666
Total	3,653

A BALANCED SYSTEM OF CARE

In 1983, Dr. Heseltine discussed the controversy around medical and non-medical approaches to treatment and the need to "balance" the system of care, offering a continuum of alternatives. His position reflects the need for one system of care and states that:

> "to view the provision of mental health services on the basis of an either/or medical/non-medical model does a disservice to those who need such services. I prefer to think in terms of a continuum of services for those who need mental health care. Some of these needs are "medical", others quite clearly are not. Therefore, the medical vs. non-medical issue is a non-issue, once it is clearly recognized that a comprehensive mental health care service system must provide for both the medical and non-medical needs in order to accommodate the wide range of disabilities and levels of dysfunction."

As well, current thinking in mental health requires some definition of primary service responsibility and roles of hospitals and other programs outside hospitals. Dr. Heseltine makes an important point in this regard in that:

> "the use of the descriptives, 'hospital/institution-based' and 'community-based', to denote where the bulk of services is provided tends to polarize

> providers and distract them from the more important consideration of the continuity of care provided through a continuum of services and environments. For example, the general hospital psychiatric unit is a resource based in and owned by the community or, as some would say, a community-based service. Although it may not always be as sensitive and responsive to all the needs of the community as one might wish, it nonetheless constitutes an important component of the total community mental health delivery system."
>
> "A common notion of 'community' appears to exclude the hospital or to view non-hospital programs based in the community as an alternative, and a superior one at that, to existing hospital (both psychiatric hospital and general hospital psychiatric unit) programs. This point of view can have harmful consequences. One has only to look at some American jurisdictions where psychiatric hospital facilities have been replaced to a large extent by 'community' mental health programs to see the results - the chronically mentally ill have often been overlooked. (e.g., Bachrach, 1976 and 1980; Gruenberg and Archer, 1979)."

For purposes of this study, the term "community" is used in two contexts. First, acknowledging Dr. Heseltine's suggestions, the term is used in reference to the client's home "community". To this end, when the principle of service accessibility is discussed, "community" is used to describe the place where the individual lives, in the sense that it is within his or her defined service area where an individual can access the comprehensive range of mental health services.

Secondly, the term "community" is used in references to the range of mental health services which are not funded or operated by a hospital. It is used to define the role and scope of the new "Community" Mental Health Management Board. At one point during the study, the Steering Committee discussed whether this Board should be responsible for "hospital-based" mental health as well as those services in the "community" or service area. It was, however, recognized that hospitals already have their own Boards in place, and due to funding, management and responsibilities for accreditation it would not be realistic to expect that hospital boards would relinquish their responsibilities to a "Community" Board.

However, with few exceptions in the Northeast, hospital providers have tended to rely on an approach to treatment based on hospitalization. As well, the prevailing competition between the hospitals in each service area and the various communities necessitated the introduction of a specific group to be responsible for community-based services. This model attempts to strike an appropriate balance between hospitals and the community services and in light of Dr. Heseltine's warnings "not to polarize providers", specific cross representation and working relationships are discussed later under organization and management of the model.

The proposed model for Northeast Ontario includes the development of a balanced continuum of care defined as "a range of mental health services located and co-ordinated within certain geographic boundaries." In this case, four service areas. Such a system is tailored to meet local community needs. Each of the four service areas discussed under the model are directed toward reasonable self-sufficiency with the essential components of mental health care in place.

ROLE OF THE PRIMARY CARE PROVIDER

One model, developed by Goldberg and Huxley in 1980 centred around the physician's role in providing mental health services. The model illustrated the critical path of the client through the mental health system and the importance of primary care providers. Their study, based on experience in the U.S. and Britain suggested that the psychiatric morbidity rate is 250 per 1,000 population at risk and illustrated the flow through the system as follows:

- out of sample population of 1,000 people at risk;
- 250 will have symptoms of mental health problems;
- 230 will seek help from G.P.s;
- 140 will have a confirmed mental health diagnosis;
- 17 will be referred to a psychiatrist; and
- 6 will be admitted to in-patient services.

Therefore, of the 250 persons with symptoms, 230 go first to the local family or general practitioner. The general practitioner makes a psychiatric diagnosis in 140 of these cases, treating 123 of the cases and referring the remaining 17 (seven per cent) to out-patient or private psychiatric services. Of these 17 referrals, six (two per cent) are admitted to a psychiatric facility. These figures provide a useful perspective on the size of the demand for mental health services and on the filtering of that demand through the various levels of increasingly specialized treatment services.

The role of the general practitioner as primary care provider is critical to gatekeeping of the system and ensuring that only appropriate referrals are made. G.P.s who participated in this study indicated that they play a role in mental health care. However, O.H.I.P. billings in the Northeast were extremely low for mental health diagnosis. G.P.s indicated a need for education in order to assume broader roles in the mental health system. This is especially important in light of traditional shortages of psychiatrists and expectations that GPs strive to maintain the chronic patient within their own communities.

An adaptation of the Goldberg and Huxley model was used for theoretical discussions during this study. As shown in Exhibit 14, a critical path shows the continuum of services required to meet the needs of individuals at various points in the system. One can trace the role of agencies and providers in the community for those at risk through to those with needs for specialized out-patient and community care. Active institutional treatment has a small but critical role in providing service at the end of the continuum.

As discussed by Dr. Heseltine; primary care by general practitioners is vital to case identification, assessment, referral and treatment of mental health problems; and

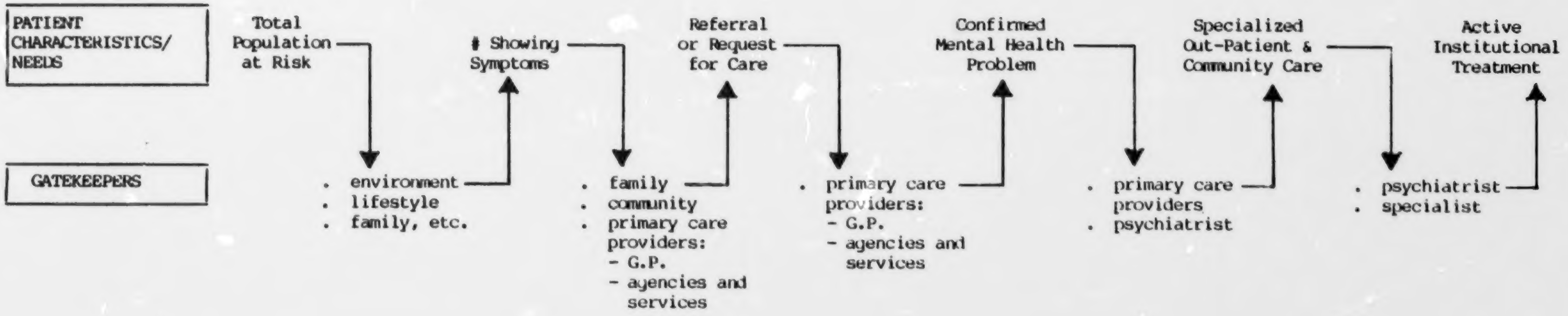
> "Without the local doctor, existing formal mental health services in this province would be swamped. The array of designated mental health service deals with only a relatively small proportion of the client population. I doubt that most of the other mental health professionals, including psychiatrists, are aware that they come in contact with only a fraction of those persons who seek and require mental health services...some patients who seek mental health services from general practitioners might be better served by other services; both the patient and the general practitioner need to be better informed about appropriate alternatives, including non-medical treatment."

Referring to the Goldberg and Huxley "critical path", Dr. Heseltine notes the importance of other gatekeepers in the system, particularly the public health nurse. Dr. Heseltine is an advocate of using such professionals in the provision of mental health services as reflected in his statement that:

> "Public health units are at the front line of community mental health services, particularly with respect to the identification of the need for such services. Public health nurses can be found in schools, hospitals, community centres, nurseries, clinics and physician practice attachments. As well as acting as gatekeepers, public health nurses are

EXHIBIT 14

A CRITICAL PATH THROUGH MENTAL HEALTH CARE


PATIENT CHARACTERISTICS/ NEEDS
GATEKEEPERS
Total Population at Risk
. environment
. lifestyle
. family, etc.
# Showing Symptoms
. family
. community
. primary care providers:
- G.P.
- agencies and services
Referral or Request for Care
. primary care providers:
- G.P.
- agencies and services
Confirmed Mental Health Problem
. primary care providers
. psychiatrist
Specialized Out-Patient & Community Care
. psychiatrist
. specialist
Active Institutional Treatment

CONTINUUM OF MENTAL HEALTH SERVICES

TYPES OF SERVICES/ ACTIVITIES	. mental health promotion . prevention of mental illness	. early case identification	. assessment/ diagnosis . case management . referral . crisis intervention . counselling	. consultation . assessment/ diagnosis . therapy . counselling . crisis intervention . rehabilation/ maintenance . accommodation/ housing	. consultation . assessment/ diagnosis . counselling . therapy . rehabilitation/ maintenance

> strategically placed to deliver mental health services on a continuum of primary, secondary and tertiary prevention through crisis intervention to maintenance and rehabilitation programs."

Dr. Heseltine further suggested that the primary contact person for the individual with a mental health problem can affect the actual diagnosis, treatment plan and the location of treatment, in that it can occur:

> "at home, professional's office, in an out-patient setting or clinic or in any number of different types of psychiatric facilities. It is my sense that, where assessments are carried out by professionals or others in the private sector, the diagnosis is more likely to be one which allows the patient or client to remain in the community and receive treatment or care on a private or out-patient basis."

Building upon the idea that "primary" contact is paramount, one Ontario model of community and hospital mental health services delivery is the Rainy River Valley Adult Community Mental Health Program. Developed 10 years ago in Fort Francis it is designed to serve a population of 23,000. An Executive Director, reporting to the Rainy River Hospital ensures that both institutional and community roles are fulfilled.

Responsibilities of workers are designed to provide continuity of care between the institution where they invest 10% of their time and the community out-patient service, where 90% of their role is focused. Mental health workers are trained as generalists and one of their priorities is to maintain the chronically mentally ill person within his or her community through good case management. Other functions include counselling, referral and mental health promotion for the general population.

Local advisory committees provide direction to workers around specific local needs. Liaison with general practitioners and other agencies has been identified as an important factor in the success of a program which places generalist mental health workers in small communities.

Since 1982, the Terrace Bay/North of Superior Community Mental Health Program has focused on ensuring access to community mental health services to a large, widely dispersed population, in Northwest Ontario. The model is unique in that:

> "...it relies upon flexible, mutually supportive exchange between funding bodies, educational resources, service providers and communities of a large, isolated, rural area." (Turner)

It serves a population of 30,000 covering 80,000 square kilometers. Considering this broad mandate, this model of service delivery uses mental health generalists to assist both children and adults within the system.

Eight workers are based in seven communities 2,500 to 3,000 in size. Responsibilities of workers are broad, ranging from case management for the chronically mentally ill individual to counselling and mental health promotion activities. Mental health workers have backgrounds in education in psychology, nursing and social work. This "critical mass" of workers is sufficient to require a full-time psychiatrist resource in Terrace Bay. Monthly meetings bring workers together for education and team support/communication of experiences which is critical to workers who otherwise work quite independently.

This program is unique in that it resulted from negotiations between the Ministry of Community and Social Services, the Ministry of Health and the University of Western Ontario and is a jointly funded, locally administered program.

MANAGEMENT AND CONTROL

The dollars available for health care, including mental health care, are not unlimited. One of the factors which hinders the development of an effective mental health treatment and care system is that there is a tendency to espouse too many goals and to choose too few priorities. "As Leighton succinctly puts it, the core of the issue is the management of limited resources, of making choices among many different kinds of humane goals" (Heseltine).

Competition amongst provider groups and communities for resources further supports the need to prioritize allocation and ensure a balance between institutional/non-institutional services for the sake of the individual client. Good management and co-ordination of the system has been a major concern of the Study Steering Committee in establishing principles for the model.

The Grey-Bruce Community Health Program, also known as the Owen Sound Model illustrates one model of community mental health services management. Instead of having a Board for each small program, one representative Board supported by an Executive Director and staff are charged with the responsibility to develop, operate and evaluate the continuum of community-based services offered. Ministry of Health funding of programs flows directly to the Board for distribution. As well, a close working relationship with the District Health Council ensures that priorities for new program funding are considered. This 3-year old program is considered by the Ministry to be working effectively in introducing better co-ordination and communication mechanisms into a previously fragmented system of providers.

HUMANE DEINSTITUTIONALIZATION

As noted by Dr. Heseltine one belief is that it can be anti-therapeutic to maintain a mentally ill person in an institution unless the medical or behavioural components of the actual illness dictate doing so. The debilitating effects of long-term hospitalization on the mentally ill have been well documented.

> "Canadian and American experiences of deinstitutionalization suggests that chronic mental patients fare no worse and sometimes fare better in the community than in institutions when adequate support is provided". The length and type of psychiatric hospitalization can stigmatize an individual; making acceptance back into the community more problematic than it need be".

As reflected in the principles for the model the Steering Committee supports these concepts and that mental health services be offered in the least restrictive environment possible and wherever possible in the individual's own community.

In support of the idea of "humane deinstitutionalization" OPSEU provided for consideration by the Study Steering Committee a proposed model of care which is adapted from the Rhode Island model. The OPSEU Model focuses on long-needed enhancements to community and institutional care tailored to address the needs of individuals within four levels of housing scenarios.

- 24-hour supervision;
- 12-hour supervision;
- 8-hour supervision (semi-independent); and
- full independent.

In support of these options, a range of the services requirements are identified as follows.

- day care programmes - recreational, social, therapeutic, etc.;
- full medical, psychiatric & pharmacotherapy;
- full social service support;
- workshops;
- vocational and recreational services;
- community social integration;
- basic job readiness training;
- adult protective social worker placement assistance;
- educational upgrading;
- full financial support;
- housing assistance;
- basic living skills training;
- community mental health clinic follow-up;
- crisis intervention;
- respite beds; and
- day hospital care.

OPSEU stresses the need to ensure the range of services are in place prior to introducing deinstitutionalization and points to numerous cases wherein the chronically mentally ill patient has been released from hospital without safe assurance of continuity of care through good case management and access to appropriate programs to maintain them at their optimum level of function.

The Massachusetts System of Mental Health Care illustrated another U.S experience in reducing the need for state institutions with the introduction of more community-based, less restrictive care options. To this end, the goal was total but gradual replacement of all state hospitals with an updated system based on "clinical principles and more closely integrated with modern medical practice".

They established three defined tiers of service:

- First Tier: Community Mental Health Services;
- Second Tier: Community Hospital and Intermediate Care Facilities for the Mentally Ill;
- Third Tier: Specialized Back-up Services.

At the start of development in 1975, 75% of mental health dollars were being spent on state hospitals, only 25% was spent on community-based services. (In Northeast Ontario, it is interesting to note that 65% of dollars are directed to institutions whereas 35% is invested in community programs.)

Within 5 years (by 1980), Massachusetts' implementation efforts had resulted in some tangible benefits, such as more day treatment, group homes and other community programs, sheltered workshops, and aftercare. New programs have allowed numbers of individuals, who would have lived in institutions or in communities with no services to live independently. Ten million dollars had been shifted from institutions to community programs. In light of 5 years of progress, author R.L. Okin was careful to point out that while the Massachusetts system is one of the most advanced in the U.S., it is still inadequate. The need for crisis intervention and selected, expanded community programs, such as drop-in centres, and acute psychiatric services are still required to provide a balanced system. Not until all components are in place, can the level of success be satisfactorily evaluated.

Perhaps one of the most progressive community-focused models of care available to date is the California System of Care, which, like the Rhode Island model stresses the need for a range of service components in the community. It is based on the philosophy that mental health services, including preventative services be provided in a manner culturally, linguistically, and age appropriate and specific to the nature of the community and the needs of the clients. These services are to be provided in the most humane manner, as close to a normal home environment as possible, and where possible in a community-based setting, without sacrificing client safety and care.

The model defines a comprehensive, balanced mental health system as one including levels of care which are not singularly available to clients who require specific treatment, but are linked to one another in a network to provide the most appropriate level or type of service for each client. A client would move through these services as determined by diagnosis and assessment; however, some clients may remain indefinitely at a certain level of care according to individual needs. Linkage between the elements of the system is essential to assuring appropriate service delivery.

Services would be culturally, linguistically and age relevant in a continuum from acute intensive treatment through various non-hospital residential programs to out-patient and community support. The system would include smaller facilities, client involvement in decision-making, immersion of the client in the community in normative settings.

The California Model recognizes there is a need for preventative services and acute intervention; however, the needs of the chronically mentally disabled have been given prime consideration in the development of the Model. The other distinctive feature of the California Model is the development of a population based standard, expressed in terms of minimum level of service per 100,000, for ensuring access to the various categories of mental health services. The service areas defined for model development in the Northeast lend themselves to the application of California standard service levels in particular areas.

* * * * *

Many of the trends discussed in this section are reflected in the principles of the model which follow.

VI. INTRODUCTION TO THE MODEL

In order to develop the model of mental health services for Northeast Ontario, it was necessary for the Study Steering Committee to establish general principles for the system with a vision to year 2001. Various models and trends in mental health care discussed in Section V are reflected in the nine principles of the model. An understanding of these operating principles and interpretation of each is critical to successful implementation and to the appropriate realignment of current providers and their roles within the system. The following presents the principles of the model with comments.

PRINCIPLE 1: The basis for the model is a comprehensive and balanced mental health system available and appropriate to all residents of Northeast Ontario.

The model defines a comprehensive system as including the full range of mental health services from promotion and prevention activities to specialized and institutional services. Balance is identified as a important part of the principle to ensure equity in resource allocation and therefore services among the essential components of the system.

A balanced system further implies that all essential service components are in place - both institutional and non-institutional which allows flexibility in individual treatment planning.

PRINCIPLE 2: The model is developed on the basis that the individual client's needs will be the primary consideration in program design and priority setting for funding.

and

PRINCIPLE 3: The needs of the chronically mentally disabled are given foremost consideration, while recognizing that there is also essential need for acute intervention and preventative services.

As indicated by the research and experience of providers, it is the chronic mentally disabled who utilize the greatest portion of mental health services. They are individuals with predictable needs for on-going support and maintenance. Advocacy and assistance in the form of case management programs are critical to these individuals' success in achieving their highest level of functioning.

On the other hand, the lack of crisis and preventative services in Northeast Ontario has long been a concern of providers in the Northeast Region. Formal programs in large centres linked to, and supporting, community hospitals' emergency functions, GP's and other agencies are critical. Furthermore, promotion and prevention programs offered by Health and non-Ministry of Health groups must be considered and their strengths recognized and integrated during model implementation.

PRINCIPLE 4: The mental health needs of the elderly living in chronic care facilities and nursing homes are addressed primarily within these settings with support from and access to the comprehensive mental health system.

This principle is built upon the belief that anyone in the course of the normal aging process may experience a mental health problem. Such individuals should have access to hospitalization for acute episodes and to the other service components wherever appropriate.

In light of the expected increases in the aged population there have been numerous discussions and proposals to the Ministry of Health for "psycho-geriatric" services. It is the Committee's position that this label is unattractive and often inappropriate resulting in unnecessary stigma for the individual.

Mental health care for the elderly, be they at home, in nursing homes or homes for the aged should be addressed individually from the perspective of total care requirements. In many cases the physical care required far outweighs the mental health aspects of care.

As well, in designing the treatment model, the Committee believes that wherever possible the system should strive to bring treatment to patients rather than patients to treatment. The latter, and unfortunately all too commonly used approach, couples the accommodation function with the treatment function, e.g. if a patient needs a different type of treatment because of a change in health status, the patient is often relocated to a different facility.

This is particularly detrimental to the elderly individual with a mental health problem as change in environment almost invariably results in disorientation and confusion. These are the very symptoms that the system is trying to treat.

The model therefore supports treatment approaches which brings treatment in a flexible manner to patients while leaving them in their residence of choice. It is not anticipated that this will entirely prevent the movement of elderly patients from one facility to another, but it is believed that this approach will go a long way towards assuring that transfers of elderly patients will be greatly minimized.

PRINCIPLE 5: The services are provided in the least restrictive environment giving due consideration to the quality of life.

This principle promotes maximum independence in caring for the individual with a chronic psychiatric disorder and strives to reduce the need for long-term care in institutional settings at a location often far removed from family and friends.

As cited by Dr. Heseltine "it is anti-therapeutic to maintain the mentally ill in an institution unless the medical/behavioural components of the actual illness dictate doing so. The debilitating effects of long-term hospitalization on the mentally ill have been documented and experiences in deinstitutionalization in the U.S. indicate that the chronic mental patient fares no worse and sometimes better in the community with appropriate supports."

Furthermore, the California model stresses that a system should be:

> "...least restrictive in terms of both attitude to clients and an environment which can help to create a non-rigid system...there would be emphasis on priorities of appropriate levels of medication, on the practical skills and rehabilitation necessary to attain independent function, the importance of normal residential settings, the assumption of ability rather than disability and positive expectations of client performance".

To this end, immersion of the client into normative settings with involvement of the client in planning for their own requirements is expected to enhance the likelihood of "successful" community living.

The statement "giving due consideration to the quality of life" is the Committee's recognition of the fact that one ultimate goal of the mental health system is to strive to place chronic psychiatric patients into normative settings. However, the environment will inevitably have to be altered somewhat to accommodate the illness-induced deficits of the clients. To place a chronic psychiatric patient into a totally normative environment generally exposes the person unfairly to stresses with which he or she cannot cope. Any attempt at community living by psychiatric patients should be accompanied by the necessary restructuring of the client's immediate environment in order to achieve the most reasonable blend between illness-induced needs and modified community living.

PRINCIPLE 6: The services will be provided in the client's community of preference, where it is possible and cost effective.

and

PRINCIPLE 7: The model ensures access to small or widely disbursed population centres.

The vast geographic area of the Northeast poses a significant challenge in service delivery. The term "Community" can have a variety of definitions, ranging from the actual city or town of residence to the broader area of the service area.

The careful planning and investment of resources is necessary to ensure that there is a critical mass of users to ensure cost effective delivery of a full continuum of services. For purposes of this study, the four service areas, all with 100,000 or more population, are charged with responsibility for the catchment population and the range of communities it serves.

There should be a mechanism in place to link individuals in small communities, (individually or collectively with a population of 2,000-3,000) to the comprehensive system of care in larger city centres, when it is not practical or cost effective to offer the service in every community. Some services are only feasible to be offered on a regional basis.

PRINCIPLE 8: The model assumes there is an integrated mental health delivery system which is sensitive and responsive to the distinct cultural and linguistic needs of the population.

The model recognizes that there are unique considerations in delivering mental health services to the francophone and native residents of the Northeast.

The 1976 Dubois Report on French Language Services pointed to specific needs for francophone capability in the North and recommended that French-speaking doctors should be sought specifically for Cochrane, Earlton, Elliot Lake, Hearst, Matheson and Vanleek Hill and that the Underserviced Area Recruitment Program specifically identify candidates with French capability. The report raised the issue of the client's 'right' to service in their language of preference stating that:

> "It is important that the patient be able to communicate freely without linguistic barriers" (especially related to mental health care)... and since we cannot hope to have a sufficient number of francophone psychiatrists in the near future, we believe the best solution is the establishment of French-language mental health teams. These teams must be made up of psychologists, social workers and nurses, specialists in psychiatric care in order to give counselling and administer therapy under the supervision of a psychiatrist."

Under the proposed model, it is the responsibility of the comprehensive mental health system to provide the community/treatment services necessary to address the special need of such populations. Consistent with Dubois' suggestions, there will be an on-going challenge to recruit and train appropriate levels of bilingual/bi-cultural, francophone and native individuals to fulfill key roles such as case managers and supportive independent living workers to ensure critical linkages and referrals between home communities and the greater mental health system. It is important to understand that the model promotes only one system of mental health care for Northeast Ontario.

The management structure, with four boards in the service areas instead of one board for Northeast Ontario is meant to provide a more local focus and allow consumer input and participation of key cultural groups in program planning and design.

PRINCIPLE 9: **The model will have a defined management infrastructure which includes program development and delivery, evaluation, funding and on-going maintenance.**

As discussed in "trends" in service delivery, it is in the best interest of the client to ensure a balanced system of care which is accessible and integrated. In order to achieve such a goal, a structure of accountability is required. Some of the greatest weaknesses identified by questionnaire respondents and interviewees were the lack of current service co-ordination, prevailing competition between providers and possible duplication of functions. It is believed that leadership and management should be the responsibility of one Board to represent and plan for the community mental health system for the population, and to work with the institutional providers to ensure a full continuum of services. As discussed under Principle 8, setting up four Boards with strong consumer representation in the services areas ensures that well informed decisions can be made on priorities and specific needs of francophone, native groups and other special user groups.

RECOMMENDED COMPONENTS OF THE NORTHEAST MENTAL HEALTH MODEL

The proposed model has an overall goal to build reasonable self-sufficiency within four designated service areas so that each will provide for the mental health needs of the population it serves. In this sense services will be available to individuals with short-term, acute needs, as well as for chronic mentally disabled individuals with long-term needs for support and maintenance. In the past the individuals with chronic needs may have been transferred to the city of North Bay due to the lack of services in local hospitals and the surrounding community. Such transfers should be reduced significantly under the proposed model.

The need for a regional adult and a regional children's service is preserved in the model. However, the regional function becomes a more highly specialized function in the context of the total system of care. It is recognized that certain types of institution-based services are offered more cost effectively on a regional basis. It is not practical nor feasible to offer highly specialized programs in every area, considering the specialized professionals required for the services. The current regional services for Northeast Ontario are thus redefined and downsized significantly in light of planned enhancements to service planning areas and the trend towards community-based services. This section presents a discussion of regional and service area components and the rationale for each.

Regional Services

The model recommends 122 beds for Northeast Ontario "regional" services as follows:

- a 26 bed adult secure service;
- a 26 bed adult specialized developmentally handicapped service;
- a 60 bed continuing care service for adults; and
- a 10 bed children's inpatient service.

Each of the four regional functions under the model is described in more detail as follows:

* Adult Secure Service

This is an existing service at the North Bay Psychiatric Hospital. It is designed for men and women who require a secure adult psychiatric inpatient facility. Essentially, three client groups will occupy such a unit;

- patients on a warrant of the Lieutenant Governor;
- patients who have been remanded by court for a thirty to sixty day psychiatric assessment prior to trial; and
- civilly committed patients who pose a degree of risk or danger which necessitates a more secure setting than that found in the average Schedule I psychiatric inpatient facility.

It is a service generally provided by Ontario provincial hospitals and one of the "essential services" identified by Dr. Heseltine in his 1983 report.

In light of Ministry of Health planning standards for secure beds, the current beds are generally considered to be sufficient to serve Northeast Ontario. For planning purposes a 26-bed unit is shown. In the past, the secure unit has been a well utilized service, reporting 95 to 100% occupancy levels at North Bay Psychiatric Hospital.

* **Specialized Adult Developmentally Handicapped Service**

There is currently no specialized psychiatric service for the developmentally handicapped in Northeast or Northwest Ontario. This role is emerging as a priority in provincial psychiatric facilities in view of the number of individuals identified with a dual diagnosis through the Tri-Ministry project in 1981/82.

As well, a study by North Bay Psychiatric Hospital showed 18 to 20 patients at North Bay Psychiatric Hospital occupy special rehabilitation beds with a primary diagnosis of mental retardation. Such individuals might be candidates for the new service.

The purpose of the service is to provide acute psychiatric intervention and behavioural oriented programs to enable the individual to return to their permanent residence, generally a group home or supervised accommodation. It supports Associations for the Mentally Retarded as they endeavour to ensure high quality of life for their clients and should eliminate the need for referrals to distant assessment units with long waiting lists.

Care must be exercised to establish admission criteria as well as a thorough and comprehensive biopsychosocial assessment protocol. A predefined length of stay of two to four months should be applied rigorously to safeguard against the risk of such a unit becoming a holding facility for difficult patients with an indefinite length of stay. Primary focus should be on comprehensive assessment and initiation of treatment which, at the time of discharge, can be transferred to the receiving facility.

* **Continuing Care Services**

These services are currently offered at North Bay Psychiatric Hospital. There are 130 beds designated special rehabilitation beds and a 24-bed social adaptation program. They are highly utilized services with reportedly some waiting lists.

While this model promotes maximum independence of the chronically mentally ill individual it must be recognized that there will always exist in the population an "irreducible minimum" of chronic psychiatric individuals who will require institutional, continuing care. Even under the best of circumstances, such individuals cannot be maintained in the community. The need for such services under the proposed model will be reduced to 60 beds based on a planning standard of 1 bed per 10,000 general population.

This standard was tested with providers and it has been suggested that 60 beds will be inadequate for the region. Despite these challenges, this number can be justified. It is recognized that the number of severely disabled individuals will be much greater than 60 in the Northeastern Region, however, the model upholds that the vast majority of the severely disabled clients can be maintained in supervised community accommodation. Only a small minority of severely handicapped patients will have a disability of such a nature that community placement is out of the question. These 60 beds are meant for that very small minority group.

Experiences in other jurisdictions such as New York State, Massachusetts and California, have demonstrated that one of the key variables that drives a mental health service delivery model is the availability of institutional beds. The quality and quantity of community mental health programs appears to be inversely proportional to the number of available institutional beds. The Northeast is challenged to focus on ways to prevent institutional living.

.. **Comments on the Social Adaptation Program**

The North Bay Psychiatric Hospital is very proud of it's Social Adaptation Program, a 24-bed unit which is based on the idea that relationships form the central core of successful mental health management for chronic psychiatric patients. However, if one accepts the notion that patients referred to this program are considered to be capable of forming relationships and benefitting from them then the patient should be capable of community living. In other words, they will spend the majority of their lives in non-institutional settings. It is a fact that chronic psychiatric patients, especially schizophrenics, have difficulty transferring knowledge learned in one setting to another. It therefore seems more appropriate to have the teaching and activities of a SAP program carried out in the community where they live and not have to transfer their learning experiences to a new environment.

The basic idea of relationship-building is preserved under the proposed model, and it is recommended that the persons best positioned to carry out such a program with the clients are primary care providers, case workers, or SIL workers. By putting chronic patients back into the communities and setting up comprehensive mental health programs for them, the groundwork is established for good long-term relationships to develop. The SAP program objectives can be met within the context of various community programs.

* Redevelopment of the Regional Facility

As mentioned in the background to the study, the NBPH facility is in extremely poor condition. In fact, the hospital has undergone several architectural/ structural evaluations, all coming to the same conclusion, that necessary renovations could cost as much as re-building the entire facility from scratch. This required the Steering Committee to make a decision on whether to recommend use of the current site for redevelopment or move the adult regional psychiatry services elsewhere.

There were a number of options considered for location of the regional service in North Bay. The three main options considered were:

- the current site;
- the North Bay Civic site (which will become available when the new North Bay District Hospital opens); and
- the new District Hospital site.

These options are discussed as follows:

- **Current Site**

  The current site, while attractive and spacious is far removed from the city of North Bay. It has long been isolated, referred to as "The Psych on the Hill". When it was built, the philosophy of mental health care evolved around providing a peaceful retreat to promote recovery. Today's philosophy is that psychiatry is an important component of the total health care system and that the psychiatrically disabled individual participates actively in programs and, wherever appropriate, should have access to experiences in the community during the treatment process.

  For these reasons, the Committee decided that other options would be more in line with current philosophies of treatment and also provide opportunities to integrate psychiatry into the mainstream of medicine.

- **The North Bay Civic Hospital Site**

  Currently a 193-bed hospital, the North Bay Civic Hospital will merge with the St. Joseph's Hospital in order to establish the new "District Hospital" complex, for which planning is well underway, and funding is being negotiated.

  Part of the North Bay Civic Hospital facility is relatively new. Built in the 1960's, there is approximately 125-bed capacity available with a useful life of another 15-20 years. It has potential to be renovated to accommodate the 112-bed regional psychiatry service or other services. While considered as a possible site, the Civic is not recommended for the following reasons:

  - First of all, the North Bay Civic Hospital is in a highly populated residential area of North Bay. Local rate-payer groups object to the idea of psychiatric patients in their neighbourhood. Specific concerns are that "there is no place for such patients to be out-of-doors on the grounds and that local playgrounds might be used to congregate". They are concerned as well about the "type" of patient who will be using the regional service - the "forensic" patient in a secure ward or the mentally retarded with behavioural problems.

Furthermore, use of the North Bay Civic Hospital site means that the psychiatry service would again stand alone in a readily identified facility, vulnerable to the same type of stigma as before. As well, this option was rejected as it fails to bring psychiatry closer to the mainstream of medicine.

The reader will remember that "psycho-geriatrics" does not exist under this model and that the 78-bed service currently at N.B.P.H. is suggested to be reclassified as a geriatric/chronic care service. The suggested service is very similar to one which is also being planned for the New District Hospital. There is, therefore, an opportunity to consider combining all chronic are beds at the North Bay Civic Hospital site. This option would be acceptable to area residents and ensure utilization of a facility with a substantial useful life.

It is recommended that the 78-bed geriatric service from NBPH be moved to the Civic site with the number of beds proposed for the new District Hospital.

.. The New North Bay District Hospital Site

The new hospital site is recommended as the optimal location for regional adult psychiatry services. There is ample property available at the site which is slightly outside the city centre with good public transit accessibility. Selection of this option fulfills the objective to bring psychiatry services into the acute care health system. Staff become better integrated and stimulated through exposure to a more diverse health care environment. The Committee believes that this option helps to reduce the stigma long associated with the "Psych on the Hill" bringing the service closer to the community.

As well, there are economies of scale and possible "savings" in annual operation costs in using one site for acute and regional psychiatry services.

- **Regional Children's Acute Psychiatry Service**

  It is recognized that the number of children and adolescents, through age 19 in Northeast Ontario will decline from 176,605 in 1986 to 159,333 by 2001 or by 10% over a fifteen-year period. The reduction, however is not expected to result in a reduced need for mental health services. In fact, professionals report that cases are becoming more complex and difficult to treat.

  There are currently 32 regional children's in-patient beds funded by the Ministry of Community and Social Services located at the Sudbury Algoma Hospital. The catchment area for the service includes all of Northeast and Northwest Ontario, south to Parry Sound and as far west as Winnipeg. With this broad mandate, it is not surprising that children's mental health centres and other providers have encountered difficulties in getting children admitted for service and reported frustration in having to refer outside their service area for such essential service.

  With this in mind, it is proposed that a smaller number of regional beds be maintained in Sudbury (10 beds) for Northeastern Ontario only. The development of additional beds and programs in each service area will enhance accessibility and reduce the need for distant referrals.

  This Regional service is recommended with 10 beds to remain in Sudbury along with the 20 children's beds in Sudbury which service Manitoulin/Sudbury. A change in location was not considered for this service as it is recognized that the recruitment of children's experts is often difficult and that significant expertise is currently available to support the 32-bed function in the city of Sudbury.

Service Areas - Mental Health System

As discussed under principles of the model, access to service is a major challenge in this study which covers 30% of Ontario land area. To this end, each of the four planning areas:

- Nipissing/Timiskaming;
- Manitoulin/Sudbury;

- Algoma; and
- Cochrane,

will achieve a high level of self-sufficiency over the coming years as the essential components of the model are introduced or enhanced to complement current strengths. As an overview, these components include:

- adult community-based services:
    - case management,
    - supportive independent living program,
    - high/medium support housing beds,
    - drop-in centres,
    - employment opportunities,
    - community mental health centres/programs,
    - mental health promotion programs;

- adult hospital-based services:
    - in-patient acute psychiatry beds,
    - ambulatory care services,
    - hostel (supervised housing),
    - crisis intervention programs,
    - geriatric outreach program;

- children's mental health centres;

- children's acute psychiatry services; and

- addictions services.

The formal mental health system is supported and must network closely with other interest groups and agencies in the community (which may be funded by Ministries other than Health, such as social services and the educational system).

The following presents a discussion of the essential components of the model for a service area and the rationale and planning standards applied to determine the basic requirements for each.

Adult Community-Based Services

There are two key positions which are considered to be critical to the successful transition from an institutional-dependent philosophy to a less restrictive care system, and to ensure continuity of care. These are the case manager and supportive independent living (SIL) workers. Such staff roles are focused on the chronic psychiatric individual and any individual who, as a result of an evaluation has been determined to be incapable of appropriately utilizing available mental health resources.

- **Case Management**

  As defined under the California model:

  > "case management is a process of identification, assessment of need, planning advocacy, co-ordination, tracking and monitoring of needs in the most efficient and effective way possible. Client needs for housing, social and recreational services are considered and met through co-ordination with appropriate agencies and programs".

  It is essential that the individual within the program be active in the planning for his/her care to ensure maximum likelihood for success. Another key factor in successful case management is linkage and on-going dialogue with the mental health network including community agencies and general practitioners.

  The case manager will work directly with current boarding home and homes for special care operators as required and facilitate the development of new housing options and community mental health programs as required.

  The public health nurse is one of the likely professionals to assume such a role - a role which is already well established and recognized in some parts of Northeastern Ontario. In small communities, the case management and treatment functions may be carried out by the same individual.

  A reasonable caseload of 25 to 30 clients per case manager is suggested which is lower than the 40 to 50 currently handled by Association for the Mentally Retarded SIL workers, due to the frequency of case manager contact which is expected, and distance to travel in the North.

- **Supportive Independent Living Program (SIL)**

  A new and exciting element of the community-based support system is the introduction of SIL workers. As with case management, the focus of the SIL program is the chronically mentally ill individual. Specifically, program candidates will require intensive assistance in one or more activities of daily living.

Such individuals may be living quite independently in an apartment, boarding home or with family or in a special housing program (e.g., residential home for special care or high support housing program). Acceptance into the program is based on a thorough assessment by the treatment team (GP/Psychiatrist, case manager, social worker) with a specific treatment plan of various support and activities incorporating a role for the SIL worker. It must be stressed that the SIL worker plays a fairly specific role in the greater mental health care system and that the program plan should identify other groups as well (the drop-in, employment plans, medication regimes, etc.) as playing a role.

SIL clients may require up to 2 hours of assistance a day or 10 hours a week. Involvement of the worker could be short-term (a matter of days) or long-term (years) in nature.

The role of the SIL worker is to provide direct assistance and supervision to promote confidence in daily living. Areas of assistance might include personal hygiene, socialization skills, cooking, housekeeping, financial management and utilizing public transit.

The key to success is that the support be provided in the client's home environment as it is often difficult for individuals with chronic mental disorders to generalize/transfer that which is learned in one location to another.

A variety of individuals from health, non-health backgrounds may be trained to fulfill this role. On average, a caseload of 10 clients per S.I.L. worker is considered to be reasonable as each client will have very different needs for support.

There is a supportive independent living program in operation in the Oakville area which builds upon approaches to care first introduced by Associations for the Mentally Retarded. The Oakville model has served as a model for consideration in the Northeast. Information on this program can be obtained by contacting the individual noted in Appendix F.

Another program which has a SIL component to it is Progress Place in North York, Ontario. This program is a community rehabilitation service which includes a clubhouse program, transitional employment program and housing programs including a range of supportive living services. It is a model community program offering a continuum of services to the psychiatrically disabled individual. Further information may be obtained by contacting the individual noted in Appendix F.

* **High/Medium Support Housing**

Supportive housing programs offering professional staff support on a 24-hour basis are generally lacking in the Northeast. There is a need to enhance and develop such housing in all service areas.

Homes will be staffed with qualified professionals to provide a high level of support and supervision to residents. This service will be for individuals in transition between hospital-care and self-sufficiency/low-support and also for some individuals who can remain in their own communities with such support, thus avoiding institutionalization. Homes should have capacity for 6 to 10 residents.

The planning standard used for estimating the number of beds for Northeast Ontario was identified in a recent Ministry of Health study on the Whitby Psychiatric Hospital redevelopment. The standard of 0.12 beds per 1,000 general population suggests that 70 beds will be needed to serve the Northeast in 2001.

This component of the system is an extension of institutional care and, as such, is considered to be a reasonably expensive mode of care. It is proposed nonetheless to support the concept of area self-sufficiency and resident "quality of life" in a least restrictive environment.

* **Drop-In Centres**

There are currently 4 or 5 drop-in centres in Northeast Ontario. Historically such centres were developed by local branches of the Canadian Mental Health Association. Programs receive Ministry of Health funding as community mental health programs.

Drop-in centres offer structured and unstructured social and recreational opportunities for chronically mentally ill individuals. Some include educational opportunities. Hours vary from days only to some weekend and evening programs, with 1 or 2 paid staff and extensive volunteer participation.

Under the proposed model, service areas are considered to each require 2 to 4 drop-in centres with 4 to 8 total staff. Locations should be carefully selected, with public transportation access.

A commitment to evening, weekend and holiday programs is essential. This is one component of the model which requires creativity and client involvement.

The drop-in centres recommended in each service area offer an opportunity for smaller communities with a recognized group of psychiatric individuals in need of the service to have a centre in their community. It is suggested that a minimum of 50 to 75 individuals are required for consideration for formal funding as a program. This is not to say that socialization opportunities for the chronic psychiatric individual will not be possible in all communities through creative linkages to other agencies and organizations such as churches, social service agencies, Salvation Army, YMCAs and YWCAs, etc. Case managers will ensure that regardless of community size, the treatment plan will capitalize on current resources and develop such opportunities for the client.

* **Employment Programs**

As defined under the model there are three levels or types of employment programs which are required in each service area including:

- supervised work sites - which may be a traditional "sheltered workshop" or incorporate a clubhouse setting as described under "drop-in centres".

  The proposed standard is 1 to 2 work sites with 3 to 6 total staff in each service area.

- job development program - which is specifically focused on working with employers to develop commitment and job opportunities for individuals as appropriate. The 2 to 3 job supervisors in each area will provide direct supervision and support to the individual and employer. A range of individuals may be trained to fulfil job site supervision roles.

This concept is relatively untested, however such a program is now being developed in the Halton Region. Details on this program can be obtained by speaking with the individual identified in Appendix F.

- employment counselling and assistance programs - should be accessible to the high potential acute or psychiatrically disabled individual through Canada Employment Centres, the educational systems, basic job readiness training and as offered by native/other special interest groups.

* **Community Mental Health Centres**

As discussed under the principles of the model, while the chronically mentally ill individual is the primary focus of the model it is recognized that preventative programs, self-help groups, education/information services and a range of counselling programs are required for the community at large.

This component of the model is extremely difficult to quantify in the sense of need which appears unlimited and there are no existing standards for planning such services. It will be the responsibility of the Community Mental Health Management Board in each area to determine the need for special programs and ensure their implementation. Such functions are currently performed by a very broad range of groups.

Adult Hospital-Based Services

Under this model, it is important for the reader to recognize that the proposed philosophy of acute hospitalization is perhaps very different than that which is currently used in Northeast hospitals. To this end, it is recommended that the accommodation and treatment functions in the acute psychiatry beds be strictly separated. The role of the acute psychiatry bed is to provide accommodation during the very critical assessment phase. Such accommodation provides access to the technology available in a general hospital and the professional skills that allow for a rapid and comprehensive assessment of a mental health crisis. Once such an assessment is completed and a treatment plan is established, continued temporary accommodation in the acute psychiatry beds may still be justified.

The model as developed so far essentially defines the target population of general-hospital based psychiatry services as those clients who are past or present users of in-patient beds or those who are deemed to be future users of beds. In all cases, these should be clients with significant mental health problems. The hospital should strive to identify the needs of this target population and develop treatment programs which specifically meet these needs. There should be no internal barriers as to whom can attend such programs.

Currently in the majority of hospitals, in-patients are not allowed to attend day treatment or out-patient programs, thus necessitating the need to set up distinct inpatient psychiatric "treatment" programs.

Because in-patient units have a high turnover rate (the average length of stay is generally around three weeks), the needs of the inpatient population shift constantly and therefore, no inpatient treatment program can be needs driven. When the hospital's target population as a whole is assessed, however, then the needs are relatively constant, and needs-driven responsive treatment programs can be developed. Such programs should be utilized by appropriate clients whether they are inpatients, staying in nearby hostels, or living anywhere in the community.

In summary, then, the primary task of the acute psychiatry in-patient unit is to provide accommodation facilitating rapid access to a comprehensive assessment capability. At times, the accommodation function may also be restrictive when the provisions of the Mental Health Act are applied, and at times, disability may be such that a phase of treatment is only practical within the hospital environment (e.g. stabilization on medication or application of ECT). The majority of the hospital-based treatment functions should be, however, equally accessible to in- or out-patients. These services plus crisis intervention and geriatric outreach are discussed as follows.

- **Acute Psychiatry Beds**

  There are currently 211 designated "acute" psychiatry beds distributed across Northeast Ontario as shown in Exhibit 15 by service area. This number includes 26 "regional" acute beds at North Bay Psychiatric Hospital. While the designated services provide 86% of patient days for a mental health diagnosis and cover 60% of admissions, other hospitals in the system also play an important role in acute psychiatric care.

Data presented in the section on hospital utilization were considered in the suggested bed allocation within service areas shown in Exhibit 15.

The Ontario Ministry of Health uses a planning standard of 0.35 to 0.40 beds per 1,000 general population to determine the number of acute psychiatry beds required. Based on this standard, the current 211 acute care beds will increase to 234, a net increase of 23 beds within the Northeast Region. While this number is small, the major challenge is the redistribution of beds between and within the service areas. Some areas require substantial increases (e.g., Algoma and Cochrane require almost double their current allocation). On the other hand, Manitoulin/ Sudbury is challenged to reduce 21 beds within their system, and Nipissing/Timiskaming, while slightly reduced will be required to redistribute beds.

In view of issues of access and distance to travel in the North, it should be noted that the more liberal standard of 0.4 beds has been applied. The Ministry suggests that 25 to 30 bed "units" are the most cost effective to operate; however the reader will note that 10 to 16 bed "services" are recommended under this model for Elliot Lake, North Cochrane and Timiskaming.

Small psychiatric "services" in these areas may or may not take the form of a separate unit within a hospital but could for example be a formal part of a medical/surgical area. As illustrated by the utilization data, hospitals in these areas already staff and use beds on general units for psychiatric treatment. With this in mind, it may not be necessary to build beds. However, the board of directors, administration and medical staff are required to make a commitment to psychiatry as part of the hospital's role, and to seek out linkages with larger centres for necessary psychiatric back-up and for referrals of the more difficult cases. Each of these areas must determine the extent to which they will formalize and staff their service. It is important to stress flexibility and creativity in developing the small services.

As discussed in the section on trends, a progressive system of mental health care requires that acute psychiatry be integrated as part of the mainstream of medicine. To this end, it is recommended that acute beds in all service areas be part of a general hospital, linked directly to ambulatory care and the active

EXHIBIT 15

"ACUTE" ADULT PSYCHIATRY BED REQUIREMENTS IN 2001

District	1986 Current Beds		2001 Bed Requirement	Net Increase/ (Reduction)	Recommended Bed Allocation	
Algoma	36	Plummer Memorial Hospital	62	26	52	Plummer Memorial Hospital
					10	St. Joseph's General Hospital Elliot Lake
Cochrane	20	St. Mary's General Hospital	43	21	33	New Timmins District Hospital
	2	Hearst/Notre Dame Hospital			10	North Cochrane
	22					
Manitoulin/ Sudbury	36	Sudbury General Hospital	80	(21)	80	Sudbury Algoma Hospital
	65	Sudbury Algoma				
	101					
Nipissing/ Timiskaming	205	North Bay Psychiatric Hospital*	49	(156)	33	New North Bay Hospital Site
					16	Timiskaming
Total	364		234	(130)		

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*Note: The 205 is calculated based on 309 total beds less 78 psychogeriatric and 26 medium secure beds.

treatment programs as described previously. The application of this philosophy is discussed in more detail later as it pertains to model applications in the service areas.

* **Ambulatory Care Service**

Ambulatory care services are an essential part of acute psychiatric treatment programs. Included under the definition of ambulatory care treatment should be:

- assessment and diagnosis;
- medication consultation and adjustment;
- acute intervention and treatment, group therapy, psychotherapy, individual therapy; and
- psychological testing.

Programs should be accessible to patients requiring acute hospitalization and also to individuals who may live at home or travel in for service and stay at the hostel. For this reason a hospital location is optimal.

It is important to understand that such programs are "active" treatment oriented with an overall objective to prevent unnecessary hospital admissions through offering active treatment to individuals living at home or in the hostel. One of the key success factors is the ensurance of evening and possibly weekend programs.

Each service area will require 1 or 2 formal services accessible to the acute psychiatry service with 10 to 15 total staff dedicated to ambulatory care functions.

* **Hostel**

The minimal supervised hostel setting is an important element of the ambulatory care service, considering that, in the Northeast, there are individuals who require active treatment and travel a distance for service but do not require acute "hospitalization". Such individuals might spend anywhere from a few days to 2 to 3 weeks at the supervised hostel, attending ambulatory care programs or visiting specialists for assessment medication adjustments, etc.

An upper limit should be set on hostel stays, as turnover should be high. The service should not be used as a substitute for housing. In cases where travel has been required, the local case manager/ambulatory care service professionals must be in direct communication to ensure that necessary linkages are in place and the individual's treatment plan has been adjusted upon referral back to the community. One or two supervised residences proposed for each service area requires 2 to 4 staff to operate.

* Crisis Intervention Programs

There are currently several small formal crisis intervention programs in the Northeast. As illustrated in the responses of organizations to the mental health survey, numerous organizations play a role in crisis intervention - from the police to children's aid, general practitioners, drop-in centres, community hospital emergency staff and nursing homes. The lack of appropriate training and back-up to the individual in dealing with crisis, however, has been identified as a major deficiency in the North.

The Northeast mental health model thus requires a formal crisis intervention program in each service area. It is suggested that professional staff be based in hospital emergency rooms to address the broad range of "crisis" situations. Furthermore, the team could promote the training of professionals in the outlying communities and offer the necessary "linkage" which has long been missing.

It is planned that each service area would have 1 or 2 formal crisis intervention programs with 6 to 8 total staff. Such staff should have either a social work or nursing background and be backed by psychiatrists or other physicians on-call in the Emergency Room.

Program hours should be flexible and be reassessed on an ongoing basis considering actual utilization patterns. Based on such patterns, it may indeed not be necessary to provide twenty-four hour staffing. However, it is suggested that afternoon and late evening shifts are the most essential service times.

* Geriatric Outreach

As discussed in the principles of the model there is a need for the elderly to have access to the mental health system, ranging from case management for the elderly psychiatrically disabled individual living in the community to assistance to the acutely depressed individual in a nursing home with no history of mental illness. As discussed under Principle 4 of the model, this idea preserves the right of any elderly person to have access to services and treatment appropriate to their condition without being labelled "psycho" geriatric. One important feature of this outreach function is a linkage to the acute care service with the recognition that the elderly may have multi-health problems and that it is essential to use a wholistic approach to their treatment.

This team of social workers/nurses would have a dual function as follows:

- consultation - e.g. support, information and assistance to providers and individuals for early case identification, preliminary assessment of problems and establishing special treatment programs; and
- treatment - e.g. linkage with the medical system to bring a multi-disciplinary team to the home (private home, nursing home/home for the aged) to prevent unnecessary admissions of the elderly and to ensure that appropriate diagnosis and treatment plan occur.

It is suggested that each service area have 4 to 5 professional staff for this service, plus a psychiatrist with expertise/interest specifically in the mental health needs of the elderly.

Children's Mental Health Centres (CMHC)

There are children's mental health centres in each of the service areas of the Northeast. CMHCs are relatively new services in the Northeast, first funded by the Ministry of Community and Social Services during the early 1980s. Total staffing of centers is approximately 110 to 119 professionals including the francophone service operated out of Sudbury Algoma Hospital. One of the major challenges reported by the CMHCs has been to access Sudbury Algoma services for their clients.

Traditionally, CMHCs or other agencies treating children and their families have very long waiting lists and carry on treatment over considerable periods of time. Furthermore, prevalence studies such as the recent and very definitive work of Dr. Offord point towards a significantly high prevalence of psychiatric disorders in the child and adolescent population of Ontario. Nevertheless, researchers such as Dr. Offord are the first to admit that prevalence figures do not translate easily into service needs, be that numbers of therapists or residential beds. Furthermore, many mental health problems in the child and adolescent population respond poorly or only partially to treatment.

Clinical supervisors at CMHCs must insist on a high degree of professionalism among the treatment staff and diagnoses have to be made clearly. A judgement is required as to whether or not treatment is feasible given the diagnosis, and if a decision to treat is made, a treatment plan should include clear objectives, reasonable timeframes and expected outcome. Traditionally, many children's treatment facilities have been reluctant in exercising sufficient rigor in these matters. It is suggested that lengthy treatments and waiting lists are to some extent a function of this problem.

Waiting lists for services provided by CMHCs are often 1 year or more for an assessment which is not acceptable. Delay in assessment can result in an unproductive school year and subsequent failures. There is some question, however, as to whether waiting lists are actually due to a shortage in professional staff or not. Other factors which may also contribute to waiting lists are:

- the lack of primary contacts (public health nurses), gatekeepers within the school system or inefficiencies in the CMHC such as poor scheduling, unmanaged cancellations; and

- lack of individual treatment plans with objectives and "cut off" criteria.

It is suggested that there are already adequate "professional" numbers to treat Northeast children and that it is a combination of these other factors which should be managed as follows. All CMHCs should initiate efforts to:

- establish internal scheduling and management systems to ensure minimum slack time and maximum professional utilization levels. To this end, establish productivity standards for professional workers;

- require a treatment plan for each client with clear objectives, timeframes and expected outcomes with a "cut off" point for children who do not benefit within a reasonable timeframe; and

- introduce front-line mental health workers (possibly public health nurses) to work full-time in the school system to provide promotion/prevention, some counselling, early case identification and referral to CMHCs as appropriate. It is suggested that each service area requires 6 to 8 workers in such roles working closely with CMHCs and other children's agencies.

These measures should be expected to reduce waiting times and provide more appropriate levels of service.

Representation by CMHCs on Community Mental Health Management Boards is recommended in the interest of better overall system communication and co-operation and improved services to families. In the best judgement of the Committee, CMHCs should remain the responsibility of the Ministry of Community and Social Services as there are no compelling reasons to suggest a transfer at this time.

* **Children's Acute Psychiatry Beds**

As discussed under Regional Services, there are 32 children's "regional" beds at the Sudbury Algoma. It is recommended that the regional function be reduced to 10 beds. This reduction is possible in light of the proposed bed complement within the four service areas.

There are no existing standards for children's psychiatric beds or definitions for the nature of services to be provided on an in-patient basis. For this reason, consultation with children's experts and identification of available in-patient beds across the province was necessary in order to establish some general guidelines for use in this study.

It appears that 10 beds per 100,000 general population is a reasonable allocation, resulting in a total need, including regional beds, of 60 to 70 beds to serve Northeast Ontario as shown in Exhibit 16. As discussed before, this study did not address the needs of Parry Sound or propose a system of care for its residents. However, it is recognized that the Sudbury Algoma Regional Children's service is its only available resource and we are suggesting a restricted focus of these 10 beds to Northeast Ontario only. To this end, an 8 to 10 bed service should

EXHIBIT 16

Children's Acute Psychiatry Beds

Service Area	Beds
Sudbury*	20
Algoma	10
Nipissing/Timiskaming	10
Cochrane	10
TOTAL	50

---

* With 10 other beds to serve the Region, the total beds in Sudbury becomes 30.

be considered by the Ministry of Health for Parry Sound/Muskoka areas.

It is recommended that all children's beds be funded by the Ministry of Health, considering the purpose of the beds and that they would be used for children

who may require the provisions of the Mental Health Act for:

- treatment orders;
- involuntary admissions; and
- safe restraint in cases where the child may be harmful to themself or others.

Children admitted to these beds will generally have a psychiatric diagnosis (e.g., depression, psychotic, autistic) or very serious conduct disorder (e.g., self-destructive).

The idea of 10 beds in the service areas outside Sudbury is to promote accessibility to family and friends and to suggest a sufficiently sized service to ensure professional resources are recruited and used. CMHC representatives support the suggestion of beds in the service areas and believe that it will be possible to attract qualified professionals to operate such services.

Location of these beds might be on a hospital paediatric ward or preferrably in a "cottage" setting proximal to the acute hospital service.

Adolescents pose a special challenge in mental health services delivery. It is reported that 16 to 19 year olds are often victims of transition between child and adulthood due to the varying definitions and criteria used by programs. It is recommended that for adolescents, a case-by-case decision is required by the primary clinician. Options in treatment should be flexible. For example:

- If the child's problem is life-long in nature, such as schizophrenia or other psychosis, they may be referred to the adult care system as a candidate for case management, S.I.L. and other programs.

- If the person is a very immature 20-year old, they may continue to access the children's service system.

Addictions Services

In December, 1985 the Ministry of Health released its Addiction Services Policy to assist in the planning of new services. The policy promotes a community orientation, emphasizing day and out-patient treatment within a continuum of care options. At the time of the Minister's announcement, the Sudbury Algoma Hospital was finalizing a major proposal for a comprehensive addictions service. This proposal was submitted for consideration by this study and since reviewed and supported by the Manitoulin/Sudbury District Health Council.

Addictions treatment has been a relatively limited service for Northeast residents. Some of the leaders in program development have been the Salvation Army, Sister's of St. Joseph and various independents. Program philosophies have generally been based on an AA or religious approach and offer short intensive programs. Few programs are large enough to provide the "continuum of services" suggested under Ministry of Health Policy. For this reason, it is suggested that the Sudbury Algoma Hospital proposal be carefully considered as a pilot which could then be applied within the other service areas, with slight modification in that this study would not support the idea of adding extra in-patient psychiatry beds for detox/acute psychotic episodes. This further suggests that if the individual is sick enough to warrant hospitalization that the psychiatric episode takes priority and the individual should access one of the 80 acute psychiatric beds in the service area.

It is important to recognize that there has been some prevailing discussion amongst mental health professionals as to whether or not "addictions" is part of mental health. The target group for addiction treatment and the corresponding approach, philosophy and follow-up required is very different from the treatment of the typical mental health client already discussed. The Sudbury Algoma Hospital proposal recognizes the need for a separate "continuum" of addictions services including the following components:

- head office;
- assessment, referral and case management services;
- a day treatment program;
- an after-care program;
- detox beds;
- supervised residence; and
- community addictions service workers.

The Sudbury Algoma model is estimated to require approximately 32 to 33 staff and a total annual operating budget of $1.9 million. Program staff will rely upon good communications with other existing programs to ensure appropriate linkages and prevent duplication of effort. The proposed staffing seems reasonable in light of the objectives and outcomes to be achieved under the program.

A strong community focused approach is planned and it is estimated that approximately 6% or 12,000 of the total population have drinking problems and could benefit from such a program. These estimates are in line with Addiction Research Foundation (ARF) projections. ARF representatives played a key role on the Addictions Services Task Force (ASTF) along with educational, public health, medical and private sector representatives in preparing the program proposal. As well, available statistics and documentation, while limited due to the scarcity of good research to date, were used in proposal development.

The pilot of this comprehensive program could be very useful to the Ministry as it proceeds to develop quanititative standards and expectations for future programs across the Province. More information on this program can be obtained by speaking with the individual noted in Appendix F.

ORGANIZATION AND MANAGEMENT

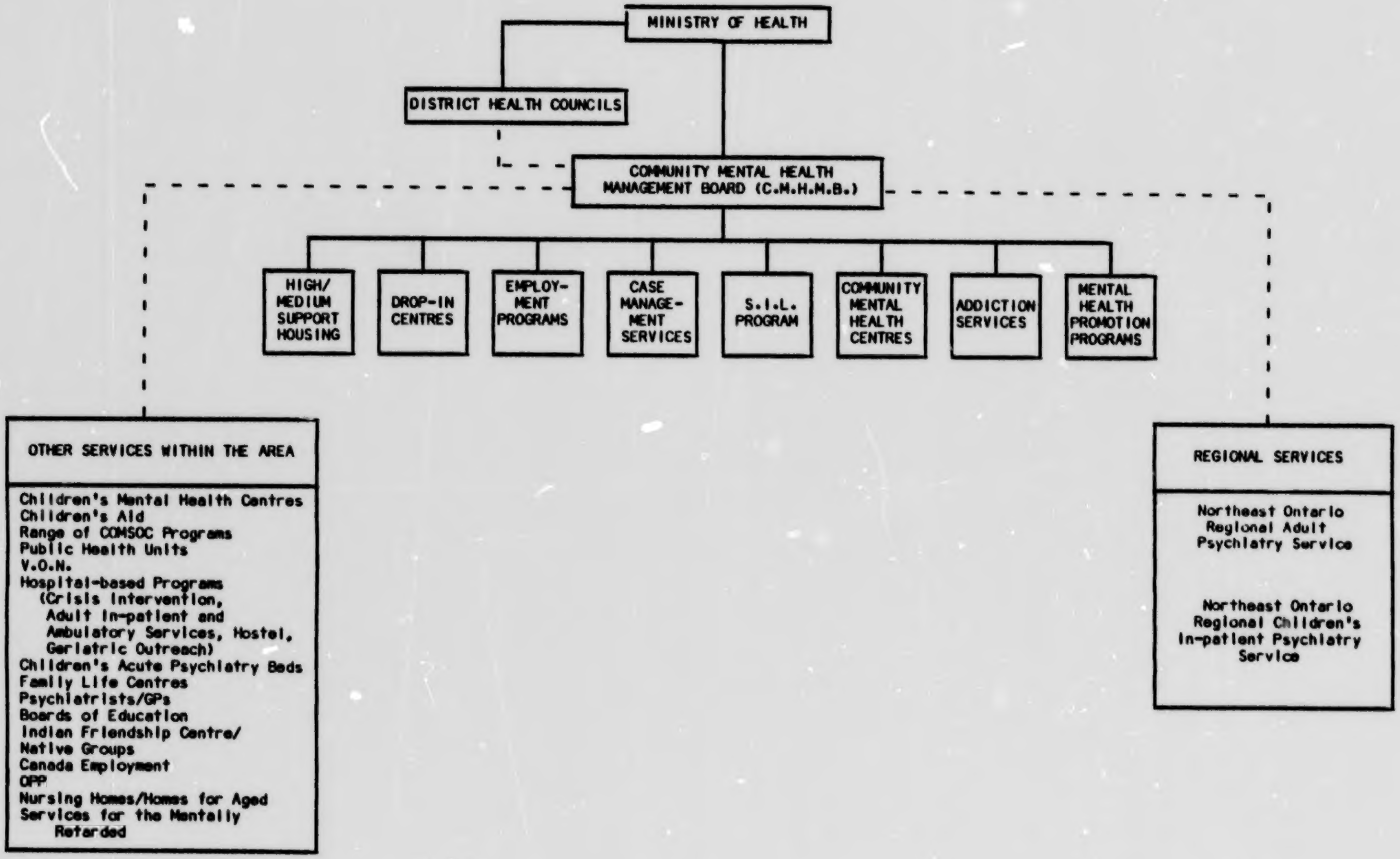
A well-defined management infrastructure is essential to ensure program development and delivery, evaluation, funding, and ongoing maintenance of the proposed model. Sound management impacts directly on the success of the future system to fulfill the principles and vision established for the model.

Exhibit 17 shows the organization of the various functions in the recommended mental health services system. The focal point is the range of essential adult community-based services which will become the responsibility of a new Community Mental Health Management Board (CMHMB). It is recommended that four CMHMBs be established, one in each of the service areas identified in this report.

Each CMHMB will have on its Board representatives from the population it serves. To this end, a mix of providers, both local and regional, children's representatives, concerned

EXHIBIT 17

"FUNCTIONAL" ORGANIZATION OF THE MENTAL HEALTH SERVICES SYSTEM IN 2001


MINISTRY OF HEALTH
DISTRICT HEALTH COUNCILS
COMMUNITY MENTAL HEALTH MANAGEMENT BOARD (C.M.H.M.B.)
HIGH/ MEDIUM SUPPORT HOUSING
DROP-IN CENTRES
EMPLOY-MENT PROGRAMS
CASE MANAGE-MENT SERVICES
S.I.L. PROGRAM
COMMUNITY MENTAL HEALTH CENTRES
ADDICTION SERVICES
MENTAL HEALTH PROMOTION PROGRAMS
OTHER SERVICES WITHIN THE AREA
Children's Mental Health Centres
Children's Aid
Range of COMSOC Programs
Public Health Units
V.O.N.
Hospital-based Programs (Crisis Intervention, Adult In-patient and Ambulatory Services, Hostel, Geriatric Outreach)
Children's Acute Psychiatry Beds
Family Life Centres
Psychiatrists/GPs
Boards of Education
Indian Friendship Centre/ Native Groups
Canada Employment
OPP
Nursing Homes/Homes for Aged
Services for the Mentally Retarded
REGIONAL SERVICES
Northeast Ontario Regional Adult Psychiatry Service
Northeast Ontario Regional Children's In-patient Psychiatry Service

citizens and special interest groups should be included. The major objectives of the CMHMB are:

- to monitor and ensure that an appropriate range of community mental health services is in place for the service area;
- to develop, operate and evaluate community-based mental health services as required throughout the service area;
- to work co-operatively with social services and hospital-based mental health services to ensure a co-ordinated delivery system;
- to identify new community mental health service needs in the service area; and
- to make recommendations to the local District Health Council on mental health needs and program priorities for the service area.

As shown in Exhibit 17, the relationship to the Ministry of Health is direct as funding will flow to the CMHMB for allocation to the various programs. The scope of responsibility of a CMHMB under this model might be 110 to 220 staff and require the management of a budget of an estimated $4 to 8 million a year. In light of this broad challenge, the establishment of 2 to 3 staff positions are suggested to support the Board; an Executive Director, a Finance/Information Officer and clerical support, at an estimated annual cost of $500,000 to $600,000 to operate four Boards.

One of the challenges raised during model testing sessions in April, 1986 was the introduction of these Boards which were considered by some as expensive and "just another hierarchy" with which the line staff must cope. The Committee considered the challenges carefully but believe that the benefits of introducing sound management far outweigh the cost. In fact, these Boards are likely to be less costly than the current system which requires even the smallest of programs to have its own Board. Like the Owen Sound model, the CMHMB replaces the numerous existing program Boards and is charged with setting priorities and making funding decisions between services based on client need.

The prevailing conflict and competition between current providers and communities (which was a major weakness identified during this study) will be managed by the CMHMB, as it has responsibility for the roles and evaluation of community-based programs. Another benefit to be considered is flexibility and responsiveness for the client. This Board function is not dissimilar from the role of the Hospital Board as it too must make annual decisions on program priorities and promote sound linkages between often competing interests.

Dr. Heseltine's message that polarization should be avoided as both systems play a role in service, communication and co-ordination amongst providers of community-based and hospital-based services, is facilitated at several levels within this model.

The first linkage is at the level of the Community Mental Health Management Board where key institutional providers must be represented, including the Chief of the acute psychiatry services. A second linkage is recommended through the cross representation and appointment of the C.M.H.M.B. Executive Director as a voting member within the Hospital Department of Psychiatry. The third linkage is the more informal day to day networking across all services which will naturally evolve as part of the role of the case manager who develops relationships throughout the service system in the interest of the individual client.

Exhibit 17 shows the linkages to "other" services within the service area, as well as to the regional psychiatry services.

Planning and Evaluation

There was some discussion during this study of the need for a "Northeast Regional Mental Health Service Committee" similar to that suggested in the 1981 Northeast Ontario Mental Health Study.

The Steering Committee supports the idea that a "Northeast Regional" voice is required to promote the interests of it's residents, especially for regional planning and service issues, university affiliation and representation on key issues to Queen's Park. It recommends that the DHCs' Mental Health Sub-Committees meet on a regular basis, as they reportedly do now, and identify and plan for mental health service issues that are of a regional nature. With regard to local planning issues, it is essential that the CMHMB have representation on the local DHC's mental health sub-committees to provide the necessary input to make planning and program priority recommendations for their service area. To this end, it is timely for the unorganized areas of Nipissing and Timiskaming to establish a District Health Council in order to ensure adequate representation at the Regional level and to plan for and co-ordinate mental health services.

Prevention and promotion is an important function of the CMHMB. As Dr. Heseltine points out, "primary" prevention programs in mental health are essential if we are to place some reasonable limits on the increasing demand for mental health services. Primary prevention programs are difficult to design and priority should be given to building upon the experience of programs which have demonstrated results. These programs include physical fitness, employee assistance and health and lifestyle promotion. Because of the large number of government, non-profit and private groups involved in mental health services in each area, involvement of such groups in the CMHMB is needed to ensure sound communication and identify areas where functions and purposes may be complementary.

It is critical to this model's ongoing success to have a systems-wide evaluation component which will monitor the implementation and ongoing needs of the Northeast population. Some of the important players in the evaluative process will be:

- District Health Councils;
- Ministry of Health;
- Community Mental Health Management Boards;
- hospital-based services;
- professionals;
- consumers; and
- universities and community colleges.

One important challenge will be to develop an information system which is common to both institution and community-based services and covers Ministry of Health and Ministry of Community and Social Services programs. The information system must also produce data which relates to goals of the individual program and of the overall system.

Some of the major issues which need to be addressed through ongoing evaluation include:

- comprehensiveness and balance;
- accessibility;
- continuity of care;
- flexibility and responsiveness to changing needs; and
- client need, satisfaction and outcome.

There is significant development work required to establish an evaluation component for this model. However, the Grey Bruce Mental Health Services Board is developing evaluation tools, procedures and methodologies which should be reviewed carefully for application in the Northeast.

It is recommended that the regional group of DHC sub-committees assume responsibility for the co-ordination and implementation of the evaluation process, preferably with a rotating chair. The Ministry of Health should allocate funding to support this effort, including the purchase of outside expertise as required.

The focus of the regional group will be evaluation of the overall system and its components. The various providers throughout the system will be required, on a regular basis, to conduct evaluations of their programs with focus on client needs, satisfaction and overall outcome. These evaluation results will be important inputs to the overall system evaluation.

Similarly, consumers should be involved in this process, through feedback on both individual programs and the overall system.

One of the first steps in establishing an effective evaluation process is the identification of performance indicators. While this step will require substantial thought and effort, the following are some suggestions as to the performance areas which will require examination:

* **System's Indicators**

Some of the major system's indicators include:

- clear statement of objectives and priorities of the Northeast system which is understood by the important players;
- an annual evaluation mechanism is in place;
- appropriate balance and availability of resources between community and hospital-based services;
- the organizational structure of the system is clear and supportive of the intent of the system;
- the channels of communication and co-ordination are well-defined, understood and effectively utilized;
- the procedure for achieving appropriate representation in the key planning and evaluation groups is effective and utilized;
- existence of duplication or gaps in services; and
- out-of-district utilization trends.

* **Program Indicators**

Some of the major program indicators include:

- appropriateness of program in relation to the system's purpose;
- utilization, admission and re-admission rates;
- change in client;
- client satisfaction;
- referral agent satisfaction;
- teaching and research efforts; and
- quality

* **Ministry of Health Indicators**

Some of the major indicators include:

- clarity of policy and priorities;
- level of funding; and
- effectiveness of communications between the Ministry and the Northeast system.

University Involvement In The System

This study recognizes the importance of the involvement and interest of universities in the ongoing development of the mental health services system in the Northeast. The major reasons for such involvement include:

- human resources for the regional, specialized care facilities;
- psychiatric support to the general hospital psychiatric unit;
- education for the mental health professionals;
- assistance to community colleges in developing appropriate programs;
- research, both collaborative and clinical; and
- evaluation procedures and tools.

The University of Western Ontario has been involved for some time in the delivery of mental services to the North though its extended campus program. In recent months the Ministry of Health has funded a Northern Co-ordinator position, responsible to the University of Western Ontario and Laurentian University, with the intent of introducing more psychiatrists and other mental health professional programs to the North.

This study supports this move and recommends that the Co-ordinator position be linked formally to the regional planning and evaluation group. As well, this position should work with the University of Ottawa to bring the necessary francophone resources and programs to the Northeast.

One of the first priorities for this position should be the identification of educational requirements resulting from the implementation of this model. In particular, the training or re-training needs will be greatest for:

- general practitioners;
- case managers;
- supportive independent living workers;
- community mental health workers; and
- emergency room staff in general hospitals.

As described later in the section on implementation, a detailed plan for staffing and re-deployment will be required in order to implement the model effectively. It will be important for the Northern Co-ordinator to be a key participant in the development and implementation of the education and training part of the plan.

VII. APPLICATIONS OF THE MODEL

This section presents a profile on each service area with guidelines for establishing a comprehensive range of services in each area. As discussed in previous sections on demographics, utilization and summary conclusions from interviews and the questionnaire, each service area has some unique characteristics. Furthermore, the range and mix of current services vary between areas.

The proposed model of services promotes a goal of reasonable self-sufficiency in each area through building on existing service strengths. In the discussions which follow, specific findings, recommendations and implementation considerations are discussed related to:

- unique demographic characteristics;
- major mental health providers;
- strengths and weaknesses;
- application of the model with corresponding staffing issues; and
- specific implementation challenges.

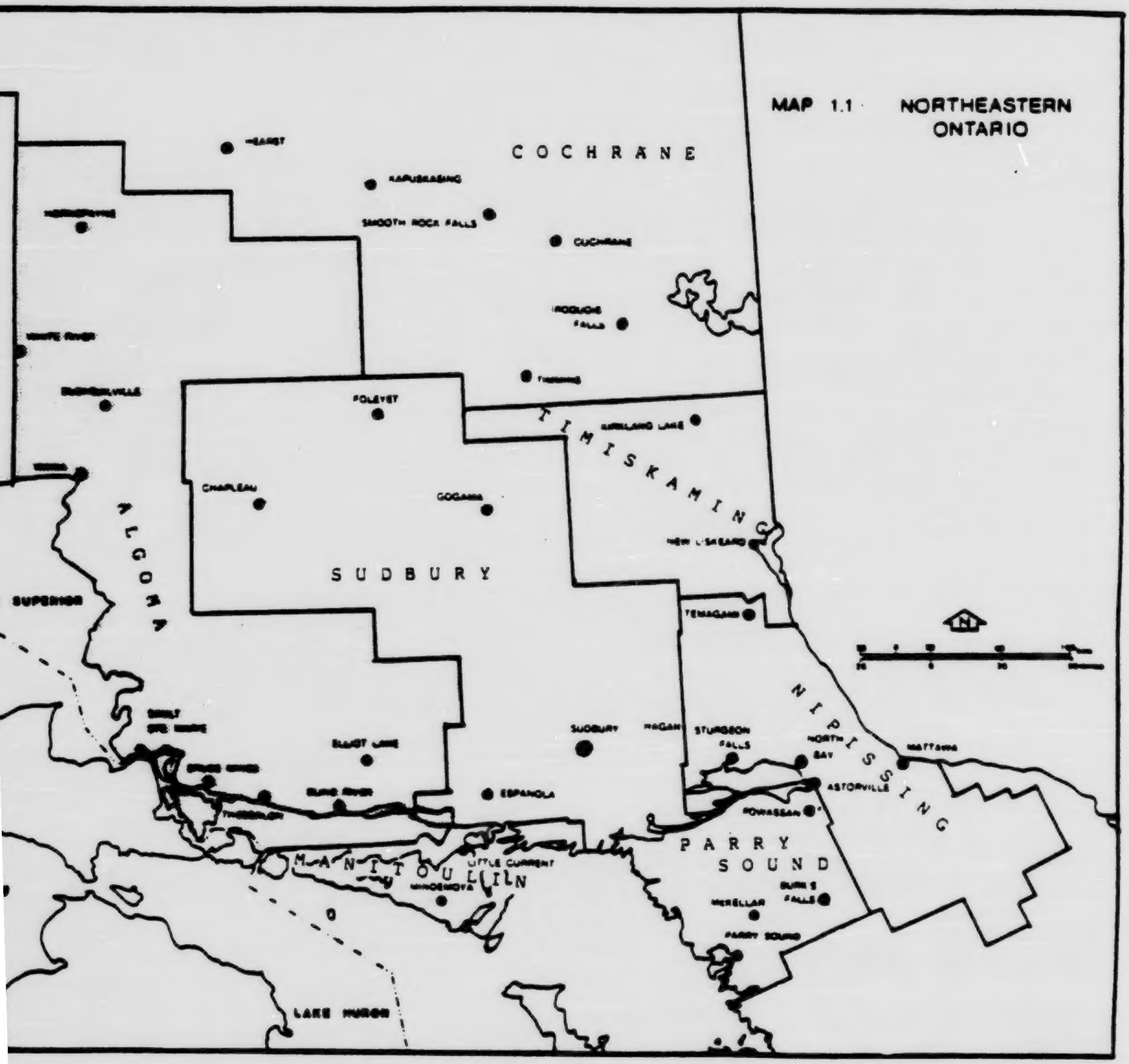
The information presented is meant to provide general guidelines for use in implementation and a preliminary indication of the staff resource needs, and the type of positions which will exist under the model. Also identified are special needs of the catchment area which must be addressed jointly by the overall implementation committee, District Health Councils and Community Mental Health Management Boards during implementation. The numbers reflected in these summaries, wherever possible are shown to reflect current mental health personnel in the Northeast and its service areas and should be considered "best" estimates, within 5 to 10% of actual numbers in all cases.

THE ALGOMA SERVICE AREA

As shown in Exhibit 18, the Algoma Service Area covers a broad geographic area and 51,206 square kilometers. Algoma extends as far north as Cochrane and borders Lake Superior and Thunder Bay west. Sudbury is the area's neighbour to the east and one notes that Elliot Lake is about halfway between the cities of Sault Ste. Marie and Sudbury.

EXHIBIT 18

NORTHEASTERN ONTARIO: ALGOMA SERVICE AREA


MAP 1.1 NORTHEASTERN ONTARIO
COCHRANE
HEARST
KAPUSKASING
SMOOTH ROCK FALLS
COCHRANE
IROQUOIS FALLS
TIMMINS
KIRKLAND LAKE
WHITE RIVER
WAWA
FOLEYET
CHAPLEAU
GOGAMA
TIMISKAMING
NEW LISKEARD
ALGOMA
SUPERIOR
SUDBURY
TEMAGAMI
N
NIPISSING
SAULT STE. MARIE
ELLIOT LAKE
BLIND RIVER
SUDBURY
STURGEON FALLS
NORTH BAY
MATTAWA
ASTORVILLE
ESPANOLA
POWASSAN
PARRY SOUND
MANITOULIN
LITTLE CURRENT
MINDEMOYA
BURK'S FALLS
MCKELLAR
PARRY SOUND
LAKE HURON

In 1981, Algoma had a population of 133,553. This results in a population density of 2.6 residents per square kilometer.

The number of Algoma residents is projected to increase 16.7%, and to 155,759 residents by year 2001. This is the only area in the Northeast where any significant increase is expected. Planners at the District Health Council use this number as a planning base but suggest that these projections are ambitious. As implementation of the proposed model proceeds, it may be necessary to reduce the number of case managers, SIL workers, etc., if the population does not in fact meet projections.

The major population centres in Algoma are:

- Sault Ste. Marie with a population of 82,697 or 61.9% of the Algoma residents; and
- Elliot Lake with 16,723 residents or 12.5% of the population.

Almost 75% of Algoma residents are represented in these two areas. Sault Ste. Marie and Elliot Lake are followed in size by the towns of Wawa with 4,206, Blind River with 3,444 and Hornepayne which has fewer than 2,000 residents.

Algoma is primarily anglophone as 77.5% of residents report English as their mother tongue. There are more residents with "other" mother tongue (12.5%) than francophones who represent only 10% or 13,355 residents. Algoma has 8 native reserves with 2,232 residents.

Algoma residents are slightly better educated than in other parts of Northeast Ontario and almost 81% of residents over age 15 have Grade 9 schooling. Employment rates are higher in Algoma than anywhere else in the Northeast with almost 80% of men and 50% of women in the labour force.

Major Mental Health Providers

Hospital Providers

The major designated hospital provider is the Plummer Memorial Hospital. It ranks third in hospital separations and patient days, preceded only by the North Bay Psychiatric and Sudbury Algoma Hospitals. The Riverview Centre complex includes the in-patient psychiatry beds and department of community psychiatry. The catchment area for services is primarily the Algoma service area. High utilization is reflected in 95% occupancy levels. Other community hospitals without designated beds, but playing a significant role in psychiatric treatment are the Elliot Lake St. Joseph's Hospital using 3 beds on average for such care and the Blind River Hospital which reported 117 admissions in 1984/85.

Algoma separations show the service area to be quite self-sufficient in that 85.1% of Algoma residents received care in Algoma hospitals during 1984/85. More Algoma patients go the Sudbury Algoma than NBPH for care. In fact as reported by Algoma GPs, 70% refer to Riverview Centre, almost 30% refer to Sudbury Algoma, no one referred to NBPH. As shown in Exhibit 19, the Plummer Memorial handles the severe mental health disorders (e.g., schizophrenia and affective psychoses), other hospitals treat mainly neurotic disorders, in fact 25% of all Algoma separations in 1984/85 were of individuals with neurotic disorders. This is followed by 17.7% separations for combined categories of alcoholism and drug dependency/abuse.

Funded Community Mental Health Programs

There are a number of formally funded programs which provide services in Algoma.

- **Medirep (Sault Ste. Marie)**

  This is a program operated by the Plummer Memorial Hospital. It has three major activities:

  - rehabilitation day treatment - an all day program for schizophrenics, self-awareness, support group for depression, fitness, leisure planning, etc.

  - crisis intervention - a small service which provides assessment, short term therapy, consultation and referral.

  - Algoma North counselling service in Wawa - an out-patient counselling service to adults and late adolescents with emotional problems.

- **East Algoma Clinic (Elliot Lake)**

  This small mental health program is funded as one of the Sudbury Algoma Hospital Clinic Programs and offers counselling, some case management and promotion/prevention interventions. Due to proximity of Elliot Lake to Sudbury, working relationships are strong. As well, the Elliot Lake, Blind River areas have a significant number of francophone residents who find treatment in Sudbury more readily available than in the Sault.

EXHIBIT 19

ALGOMA
1984/85 SEPARATIONS AS % OF HOSPITAL TOTAL

		SAULT STE. MARIE	PLUMMER MEMORIAL	ELLIOT LAKE & ST. JOSEPH'S	HORNEPAYNE	LADY DUNN GENERAL	THESSALON HOSPITAL	MATTHEW'S MEMORIAL	BLIND RIVER	TOTAL ALGOMA
290	SENILE & PRE-SENILE	6.2	1.5	1.2	0.0	0.0	4.0	5.9	6.8	2.2
291	ALCOHOL PSYCHOSIS	7.7	3.1	2.4	9.4	0.0	0.0	0.0	0.9	3.0
292	DRUG PSYCHOSIS	0.0	1.4	1.2	0.0	0.0	0.0	0.0	0.9	1.1
293/4	OTHER ORGANIC PSYCHOSIS	0.0	0.1	0.6	0.0	0.0	0.0	0.0	0.0	0.2
295	SCHIZOPHRENIA	0.0	16.0	4.1	3.1	13.6	0.0	0.0	1.7	11.3
296	AFFECTIVE PSYCHOSIS	3.1	18.4	10.7	0.0	0.0	12.0	5.9	2.6	13.7
297	PARANOID STATE	0.0	0.6	2.4	0.0	0.0	0.0	0.0	0.0	0.7
298/9	OTHER PSYCHOSIS	4.6	2.9	2.4	3.1	4.5	0.0	5.9	0.9	2.8
300	NEUROTIC DISORDER	13.8	21.9	35.5	43.8	29.5	56.0	35.3	19.7	24.8
301	PERSONALITY DISORDER	0.0	6.1	3.6	0.0	0.0	0.0	5.9	0.9	4.5
303	ALCOHOLISM	36.9	9.7	20.1	12.5	22.7	16.0	0.0	23.1	14.3
304/5	DRUG DEPENDENCY & ABUSE	3.1	2.3	7.1	0.0	9.1	4.0	5.9	3.4	3.4
308	ACUTE REACTION TO STRESS	0.0	0.3	0.0	0.0	0.0	0.0	0.0	20.5	2.1
309	ADJUSTMENT REACTION	0.0	3.8	0.0	6.3	6.8	0.0	0.0	0.9	2.9
313	EMOTIONAL DISTURBANCE CHILDHOOD & ADOLESCENCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
302/6/7/10/11/12/16	OTHER NON-PSYCH DISORDER	24.6	8.2	8.9	21.9	13.6	8.0	35.3	17.9	11.0
314	HYPERKINETIC SYNDROME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
315	DELAY IN DEVELOPMENT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
317/8/9	MENTAL RETARDATION	0.0	3.5	0.0	0.0	0.0	0.0	0.0	0.0	2.2
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SOURCE: MINISTRY OF HEALTH DATA DEVELOPMENT BRANCH

- **Beginnings Transition House (Sault Ste. Marie)**

  This program provides transitional accommodation for eight adult psychiatric patients who have the potential for independent living but who also need assistance and supervision. It provides an alternative to continued hospitalization and attempts to prevent readmissions by adequately preparing the patient to live independently. Adults and adolescents are considered for the program.

- **P.A.R. Mental Health (Sault Ste. Marie)**

  Managed and operated by Mental Health Sault Ste. Marie, it is a social rehabilitation program, drop-in centre which uses extensive volunteer support. It offers weekly group sessions, is not restricted to clients with a history of admission to an institution for psychiatric care and is open to referrals by a range of hospital and community- based providers.

- **Algoma District Health Unit**

  The Algoma District health unit has recently received approval for a mental health case management program.

Addictions Services

There are a number of addictions services available in the area:

- **Plummer Memorial Detox (Sault Ste. Marie)**

  This is a 15 bed service (11 male/4 female capacity) which provides a protective short-stay setting for persons withdrawing from the effects of acute alcoholism. Rest, nutrition, group therapy, and one-to-one counselling are stressed, with referrals to other agencies.

- **Camillus Centre (Elliot Lake)**

  This is the alcohol treatment program operated by the St. Joseph's General Hospital. It provides out-patient, 28-day intensive treatment for men and women suffering from alcoholism.

- **Addiction Research Foundation**

  The Addiction Research Foundation plays a role in promotion, prevention, consultation, referrals and planning and co-ordination.

Other players in addictions services include the Ken Brown Recovery Home, Salvation Army, Breton House, Algoma Substance Abuse Counselling Centre for Women and Addictions Counselling for the Family Unit in Elliot Lake.

Children's Services

The major children's services in the Algoma Service Area include:

- **Algoma Child and Youth Services (Children's Mental Health Centre); and**
- **Children's Aid of Algoma.**

* * * * *

As reported in the mental health questionnaire, many other groups/agencies have roles in mental health, such as Boards of Education, Ministry of Community and Social Services (MCSS) funded programs, the Canada Employment Centre, Big Sisters and police.

Planning Bodies

Algoma has a District Health Council with an active mental health sub-committee. The MCSS regional office considers mental health to be a very important role (case management, crisis programs, counselling, planning, etc.). The local Group Health Center and the Ministry of Northern Affairs are also interested in improved planning and co-ordination.

This points to the need to integrate such groups into the CMHMB which is developed for Algoma.

Strengths and Weaknesses

Algoma had a response rate to the questionnaire of 35% of general practitioners and 31% of other groups who received questionnaires or were interviewed. Seven or 26.9% of total GPs who responded to the question on strengths identified addictions treatment as a strength, others reported the Riverview Centre, psychiatrists and "mental health clinic" as strengths. Other providers and agency respondents thought dedicated, qualified personnel to be a strength, while 20% of respondents reported no strengths in the service area. There was not much consensus nor strong indication that there were many strengths to be preserved under the new model.

There was a higher response rate to the question on weaknesses. Thirty percent of GPs thought the greatest weaknesses to be lack of psychiatrists, 26% considered lack of beds/facilities to be a weakness. A variety of other weaknesses included:

- lack of children's services;
- long waiting lists;
- lack of bilingual services;
- underservicing of rural areas; and
- lack of francophone services in the North Shore and Elliot Lake.

According to 50% of other providers/agencies, the greatest weakness in Algoma services is lack of communication and co-ordination of mental health services; 34% view the lack of children's/adolescent services to be a weakness and the same percentage believe lack of professional personnel is also a weakness.

Application of the Model

As shown in Exhibit 20, the Algoma population base used is 155,800 for a model which should be fully implemented by year 2001. The chronic population, the major user group is estimated to be 975 based on 6.25 chronic users/1,000 general population.

The regional psychiatry services are shown in the model for Algoma as service area residents will have access to these highly specialized services where appropriate. Otherwise, the services which are identified within the service area should be sufficient generally to meet the needs of the population.

Case Management

Currently a range of groups perform the case management function. A new program for case management is being developed by the Algoma District Health unit with public health nurses in this role. This should be a good starting place for enhancements which will be required to reach a level of 32 to

ALGOMA MENTAL HEALTH SERVICES MODEL APPLICATION IN YEAR 2001
GENERAL POPULATION BASE: 155,800
CHRONIC PSYCHIATRIC POPULATION: 975

	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
REGIONAL PSYCHIATRIC SERVICES			
1. ADULT SECURE UNIT	REGIONAL SERVICE - 26 BEDS	24 BEDS WITH STAFF AT N.B.P.H.	
2. SPECIALIZED ADULT DEVELOPMENTALLY HANIDCAPPED UNIT	REGIONAL SERVICE - 26 BEDS	NOTHING FORMALIZED IN NORTHEAST OR NORTHWEST ONTARIO, HOWEVER THERE ARE 10 PATIENTS IN N.B.P.H. SPECIAL REHABILITATION BEDS WHO MAY QUALIFY.	26 BED DEVELOPMENTALLY HANDICAPPED UNIT WITH 27-30 STAFF; POSSIBLE MIX 60-70% PROFESSIONAL RN'S
3. ADULT CONTINUING CARE UNIT	REGIONAL SERVICE - 60 BEDS	SPECIAL REHABILITATION UNITS WITH 154 BEDS AND STAFF AT N.B.P.H.	
4. CHILDREN'S IN-PATIENT UNIT	REGIONAL SERVICE - 10 BEDS	32 BEDS AT SUDBURY ALGOMA SERVING NORTHEAST/NORTHWEST ONTARIO, PARRY SOUND, MUSKOKA AND BEYOND	REFOCUS OF THE 10 CHILDREN'S BEDS ON NORTHEAST ONTARIO ONLY
ESSENTIAL COMPONENTS OF THE MENTAL HEALTH SYSTEM IN THE SERVICE AREA			
5. ADULT COMMUNITY-BASED SERVICES			
- CASE MANAGEMENT SERVICES	32-39 CASE MANAGERS	A FRAGMENTED FUNCTION PERFORMED BY A RANGE OF GROUPS: ALGOMA DISTRICT HEALTH UNIT - 3 CASE MANAGERS SOCIAL WORKERS IN HOSPITALS COMMUNITY MENTAL HEALTH PROGRAMS ASSOCIATION FOR THE MENTALLY RETARDED (FOR DEVELOPMENTALLY HANDICAPPED WITH DUAL DIAGNOSIS). COMSOC	29-36 CASE MANAGERS
- SUPPORTIVE INDEPENDENT LIVING (S.I.L) PROGRAM	12 S.I.L. WORKERS	NOTHING	12 S.I.L. WORKERS
- HIGH/MEDIUM SUPPORT HOUSING	19 BEDS WITH 20-25 TOTAL STAFF	BEGINNINGS TRANSITION HOUSE - 8 BEDS WITH 3-4.5 STAFF	2 HOMES WITH 11 BEDS AND 17 - 20.5 ADDITIONAL STAFF

EXHIBIT 20

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- DROP-IN CENTRES	2-4 CENTRES WITH 4-8 TOTAL STAFF	MENTAL HEALTH SAULT STE. MARIE CLUB 84 - 1.5 STAFF	1-3 NEW CENTRES WITH ADDITIONAL 2.5 TO 6.5 STAFF AND EXTENSIVE VOLUNTEER INVOLVEMENT
- EMPLOYMENT PROGRAMS			
. SUPERVISED WORK SITES	1-2 WORK SITES WITH 3-6 TOTAL STAFF	NOTHING DEVELOPMENTAL ASSESSMENT SERVICES (FOR INDIVIDUALS WITH DUAL DIAGNOSIS)	1-2 WORK SITES WITH 3-6 TOTAL STAFF
. JOB DEVELOPMENT PROGRAM	2-3 JOB SUPERVISORS	NOTHING	2-3 JOB SUPERVISORS
. EMPLOYMENT COUNSELLING AND ASSISTANCE PROGRAMS	ACCESS TO PROGRAMS FOR HIGH POTENTIAL PEOPLE	CANADA EMPLOYMENT CENTRES CANADA MANPOWER BOARDS OF EDUCATION SOCIAL SERVICES BOARD COMMUNITY COLLEGE PROGRAMS COMSOC MARCH OF DIMES - REHABILITATION PROGRAMS (FOR PHYSICALLY DISABLED)	
- COMMUNITY MENTAL HEALTH CENTRES	BROAD RANGE OF COUNSELLING, EDUCATION, PREVENTION AND SELF-HELP PROGRAMS AS APPROPRIATE TO MEET LOCAL NEEDS.	FUNCTIONS PERFORMED BY A BROAD RANGE OF GROUPS: NORTH ALGOMA COUNSELLING SERVICES IN WAWA - 2 STAFF MEDIREP PROGRAMS ALGOMA EAST (THESSALON AND RICHARD'S LANDING) SAULT STE. MARIE GROUP HEALTH ASSOCIATION EAST ALGOMA MENTAL HEALTH - ELLIOT LAKE (OUTREACH FROM SUDBURY ALGOMA) - 2-3 STAFF	THIS COMPONENT IS DIFFICULT TO QUANTIFY IN THE SENSE OF "NEED" WHICH APPEARS UNLIMITED - PRIORITIES MUST BE DETERMINED BY THE SERVICE AREA

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- COMMUNITY MENTAL HEALTH CENTRES (CONT'D)		PLUMMER MEMORIAL OUT-PATIENT PROGRAM - 5 PSYCHOLOGISTS	
		INDIAN FRIENDSHIP CENTRES	
		PUBLIC HEALTH NURSES, V.O.N.	
		YMCA AND YWCA	
		BIG BROTHERS/BIG SISTERS	
		TOUGH LOVE	
		CHILD AND FAMILY CENTRE - 3 STAFF	
		JOHN HOWARD SOCIETY	
		FAMILY SERVICES CENTRE - 8-9 STAFF	
		FRIENDS OF SCHIZOPHRENICS	
		TELECARE	
		MENTAL HEALTH - S.S.M.	
		RECOVERY INCORPORATED	
- OTHER LOCALLY DEVELOPED SERVICES		RESIDENTIAL HOMES FOR SPECIAL CARE - 16 BEDS IN 5 HOMES	ACCESS TO CASE MANAGEMENT SERVICES AND S.I.L. AS APPROPRIATE
6. ADULT HOSPITAL-BASED SERVICES			
- CRISIS INTERVENTION PROGRAMS	1 OR 2 FORMAL PROGRAMS WITH 6-8 TOTAL STAFF	MEDIREP CRISIS CENTRE - 2-3 WORKERS	1-2 PROGRAMS FORMALIZED WITH 4-5 ADDITIONAL STAFF
		PLUMMER MEMORIAL - OUT-PATIENT SERVICE	
		COMMUNITY HOSPITALS	TRAINING FOR COMMUNITY HOSPITALS AND OTHER AGENCIES WITH STRONG NETWORKING AND COMMUNICATIONS
		FAMILY SERVICES CENTRE - S.S.M.	
		ALGOMA DISTRICT SEXUAL ASSAULT CENTRE	
		TELECARE - SAULT STE. MARIE	

CONTINUED...

	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)			
- CRISIS INTERVENTION PROGRAMS (CONT'D)		NORTH ALGOMA COUNSELLING SERVICE CHILDREN'S MENTAL HEALTH SERVICES C.A.S. PUBLIC HEALTH NURSES, V.O.N. OPP GP'S NATIVE WORKER - HORNEPAYNE HOMES FOR THE AGED, NURSING HOMES HOMES FOR SPECIAL CARE JOHN HOWARD SOCIETY COMSOC WOMEN IN CRISIS OUT-REACH CHADWICK HOME	
- "ACUTE" PSYCHIATRY BEDS	62 BEDS WITH 63-68 TOTAL STAFF	36 BEDS - PLUMMER MEMORIAL WITH STAFF - EST. 40 STAFF ST. JOSEPH'S GENERAL HOSPITAL - ELLIOT LAKE - 7-9 STAFF	16 BEDS AT PLUMMER WITH 13-16 ADDITIONA STAFF 10 BEDS DESIGNATED IN ELLIOT LAKE WITH ADDITIONAL STAFF TOTAL 26 BEDS WITH 16-19 TOTAL STAFF
- GERIATRIC OUTREACH PROGRAM	4-5 STAFF	NOTHING	4-5 STAFF
- AMBULATORY CARE SERVICES	2 FORMAL SERVICES TO SUPPORT THE IN-PATIENT FUNCTION WITH 20.5-25.5 STAFF	MEDIREP "REHABILITATION DAY TREATMENT" - 4 STAFF PLUS 1.5 OT/RECREATION	2 SERVICES WITH A RANGE OF TREATMENT PROGRAMS - 15-20 ADDITIONAL STAFF
- HOSTEL SERVICE	1-2 HOSTELS WITH 2-4 TOTAL STAFF	NOTHING	1-2 HOSTELS WITH 2-4 TOTAL STAFF

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
7. CHILDREN'S ACUTE PSYCHIATRY BEDS	10 ACUTE CARE BEDS WITH 13-16 TOTAL STAFF	NOTHING	10 BEDS WITH 3.5 STAFF ON DAY/EVE; 1 R 2 CHILD CARE, 0.5 RECREATION THERAPIST; 1 RN AND CHILD CARE WORKER AT NIGHT (13-16 TOTAL STAFF)
8. CHILDREN'S MENTAL HEALTH CENTRE	21-22 STAFF	ALGOMA CHILD AND YOUTH SERVICES - 14 STAFF	ESTABLISH PUBLIC HEALTH NURSES WITHIN THE SCHOOL SYSTEM - 7-8 SCHOOL-BASED MENTAL HEALTH NURSES
9. PSYCHIATRISTS	16 PSYCHIATRISTS	2 PSYCHIATRISTS, 1 FULL-TIME GP SPECIALIST IN MENTAL HEALTH	14 PSYCHIATRISTS
10. ADDICTIONS SERVICES PROGRAM COMPONENTS INCLUDE: - HEAD OFFICE - ASSESSMENT, REFERRAL AND CASE MANAGEMENT - DAY TREATMENT PROGRAM - AFTER-CARE PROGRAM	ONE COMPREHENSIVE PROGRAM PER SERVICE AREA TO COMPLEMENT AND ENHANCE EXISTING SERVICES	NOTHING EXISTS IN THIS FORM CURRENTLY	SUDBURY ALGOMA PILOT FOLLOWED BY THE TAILORING AND ESTABLISHMENT OF THE SERVICE WITH STAFF ALGOMA REQUIREMENTS: 20-25 STAFF PLUS SPACE, EQUIPMENT
- DETOX BEDS		PLUMMER MEMORIAL HOSPITAL DETOXIFICATION SERVICE - 15 BEDS AND 8 STAFF	
- SUPERVISED RESIDENCE			
- COMMUNITY ADDICTION SERVICES WORKERS			
EXISTING SERVICES:		KEN BROWN RECOVERY HOME - 14 BEDS WITH 4 STAFF BRETON HOUSE SALVATION ARMY	LINKAGES TO THE COMPREHENSIVE PROGRAM A APPROPRIATE

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	**2001 REQUIREMENTS**	**CURRENT SERVICES**	**NET ENHANCEMENTS/ADDITIONS**
EXISTING SERVICES (CONT'D)		CAMILLUS CENTRE - ELLIOT LAKE - 5 STAFF (MEN/WOMEN - DAY CARE)	
		ALGOMA SUBSTANCE ABUSE REHABILITATION CENTRE - COUNSELLING FOR WOMEN - VOLUNTEERS	
		HALF-WAY HOUSES IN SAULT STE. MARIE	
		ADDICTION RESEARCH FOUNDATION - SAULT STE. MARIE, 3 STAFF	
		ADDICTION COUNSELLING FOR THE FAMILY UNIT - ELLIOT LAKE FAMILY LIFE CENTRE, 1.2 STAFF	

39 case managers. The Public Health unit and CMHMB should work together to build this program.

Case managers should be distributed across the service area with Sault Ste. Marie and Elliot Lake likely having the majority of case managers but the towns of Blind River, Wawa and Hornepayne and perhaps the combined areas of Bruce Mines/Thessalon warrant consideration. It is recommended that francophone and native individuals be recruited as case managers, including 3 to 4 francophone case managers and 4 to 5 native individuals. The latter should provide necessary linkages to the reserves and address specific needs of native people living in the cities.

Supportive Independent Living Program (SIL)

There is nothing formalized or similar to this program in existence and 12 SIL workers will be required to be recruited and trained. This should include a minimum of 1 francophone and 1 native SIL worker.

High/Medium Support Housing

The Beginnings Transition House is a good starting place and Algoma is the only area with such a resource. An additional 2 homes with staff are recommended. Location of the homes will be in areas with a full range of psychiatric services. As the role of the Elliot Lake in-patient services is developed, this area may be considered for one of the 2 homes.

Drop-In Centres

The P.A.R. program, or Club 84, is the only drop-in centre in Algoma. This program should continue and other areas such as Elliot Lake may require a service as more psychiatrically disabled individuals remain in the service area. A range of 2 to 4 programs is suggested as there may be other areas which begin to identify needs for such a service.

Employment Programs

Algoma requires a range of "employment" programs for individuals with mental health problems. There is a need for 1 or 2 work sites which might take the form of a sheltered workshop or be creatively developed as a program of the drop-in centre (similar to the Progress Place model). A work site will be required in the Sault as a priority.

A job development program with 2 or 3 staff is required, and for high potential candidates, relationships should be developed between mental health workers and organizations such as Canada Employment Centres, Boards of Education and community colleges. Such programs are required with respect to high potential individuals and access should be facilitated by the case manager and job supervisor who would be working already with the client.

Community Mental Health Centres

Current staff who perform functions of counselling, education, prevention and self-help programs are preserved under the model. However the CMHMB will need to consider these programs in the context of the specific target group served and in light of expected outcomes and results.

As suggested for children's mental health centres, clearly defined plans are required to ensure that resources are utilized in a cost-effective manner. Demand for such special services could be infinite and it will be the responsibility of the CMHMB to work with the DHC to carefully prioritize requests for new programs.

As noted, there are currently many programs, including MCSS funded and volunteer agencies which are involved in such services.

Residential Homes for Special Care

Residential homes for special care provide room, board and custodial care for chronically mentally ill individuals and are funded by the Ministry of Health. These homes should be considered as part of the range of housing option in the community available to individuals with chronic mental disability. Case managers would work with home operators, apartment superintendents and home operators to provide support and assistance and to maintain the client at his/her optimal level of function. SIL workers will be assigned to residents in residential home for special care as appropriate to the individual's treatment plan. There are 5 residential homes with 16 beds in Algoma.

Crisis Intervention Programs

The Medirep Crisis Centre is an existing service at Plummer Memorial which could be expanded. As well, the Elliot Lake St. Joseph's Hospital may wish to develop a service to complement its psychiatry services. Formal programs with trained staff should assume a leadership role in educating other hospital staff throughout the area to deal with mental health and other crises. They could also assist mental health workers in small communities to develop policies and procedures for dealing with a crisis.

Acute Psychiatry Beds

There are 36 beds at the Plummer Memorial Hospital, however St. Joseph's General Hospital is recognized to also provide acute services. Staff is estimated based on a 1:4 bed to staff ratio in order to develop broad estimates of current staff and to establish some general projections around enhancements.

Under this model the Plummer Memorial Hospital requires 16 beds and it is suggested that a 10-bed service be developed in Elliot Lake.

Geriatric Outreach

This program requires 4 to 5 professional staff, assisted by a psychiatrist. The program will likely be based out of Plummer Memorial Hospital with out-reach workers travelling to smaller communities in order to provide services.

Ambulatory Care Services

Such services are recommended to provide active treatment programs to support the acute psychiatry in-patient unit (at Plummer and in Elliot Lake). It will be available to patients who travel in to receive services, those staying at the hostel and to the community, with an appropriate GP/Psychiatrist referral. The Medirep Day Treatment program is one type of program which might be offered as part of ambulatory care.

Hostel

One or two hostels are required to accommodate patients involved in ambulatory care who may travel a distance for care, yet not require hospitalization.

Children's Acute Psychiatry Beds

There are no such beds in Algoma currently. Ten beds with staff are recommended and will likely be developed at/near Sault Ste. Marie, Plummer Memorial Hospital. As discussed previously, this service should bring a major improvement to services to children in each service area. A child psychiatrist or psychiatrist with appropriate experience should be recruited to offer this service.

Children's Mental Health Centres

The Algoma Child and Youth Service is an important element/strength of the mental health system. Enhancements to the services of children's mental health centres in all service areas are suggested with the introduction of public health nurses working in mental health within the school system.

Psychiatrists

Based on a standard of 1 psychiatrist per 10,000 general population the Algoma area has an extreme shortage of psychiatrists. There are only 2 psychiatrists practising in Sault Ste. Marie. Another 14 psychiatrists would be required to bring Algoma to a target of 15. This shortage was identified as a major weakness in current services. However it should be noted that the model proposed is not dependent upon psychiatrists and recommends GPs be trained and developed to deal with the supportive, on-going maintenance needs of psychiatrically disabled individuals in their communities.

Addictions Services

Algoma has a detox service in Sault Ste. Marie and various treatment programs in place such as Camillus Centre in Elliot Lake. The Sudbury Algoma model offers a comprehensive range of treatment options which could be introduced in Algoma to complement current services. Addictions services are identified by GPs as a strength to be preserved under the model.

Implementation Considerations

Providers and agencies in Algoma suggested the following major obstacles to be addressed in implementing a new mental health services model. These are ranked in order of respondent frequency.

- 55% said lack of funding;
- 53% said lack of communication;
- 28% said lack of planned approach;
- 18% report distance/isolation;
- 15% thought public attitudes would need to be changed;

Some of the major implementation activities which must take place in Algoma are:

- establishment of the CMHMB utilizing the expertise of current key players;

- strengthening of communication/co-operation between agencies and providers through the introduction of the CMHMB with specific plans for new services;
- education and promotion of the model to prepare the public for the model and it's new service components.
- redefinition of treatment and accommodation functions by providers;
- planning and construction of new beds at Plummer Memorial Hospital;
- development of an acute psychiatry/ambulatory service in Elliot Lake;
- planning of a children's in-patient service and recruitment of children's experts to lead children's psychiatry;
- recruitment of a minimum of 5 additional psychiatrists;
- specific recruitment and deployment of french-speaking mental health professionals, in communities such as Elliot Lake, Blind River area, Hornepayne and Wawa areas; in light of total requirements for staff it is estimated that 25 to 30 francophone or fully bilingual workers and 20 to 25 native workers are required to be available across the range of essential services;

* * * * *

As shown in Exhibit 21, Summary of Positions in Mental Health, Algoma currently has 112 to 119 mental health positions and requires 258 to 305 in order to implement the proposed model. To this end, staffing of mental health services in Algoma will more than double, costing an estimated $9 to $11 million a year for staffing.

THE COCHRANE SERVICE AREA

As shown in Exhibit 22, the Cochrane Service Area covers a broad geographic area and 145,618 square kilometers, extending north, beyond the area shown in this map, as far as Moose Factory/Moosonee and Fort Albany. In land area, Cochrane is the largest of the four defined service areas; three-times the size of Algoma or Manitoulin/Sudbury. At the west, Cochrane borders Algoma and the Northwest Region while the southern part borders the Sudbury and Timiskaming areas. It's eastern neighbour is the Province of Quebec.

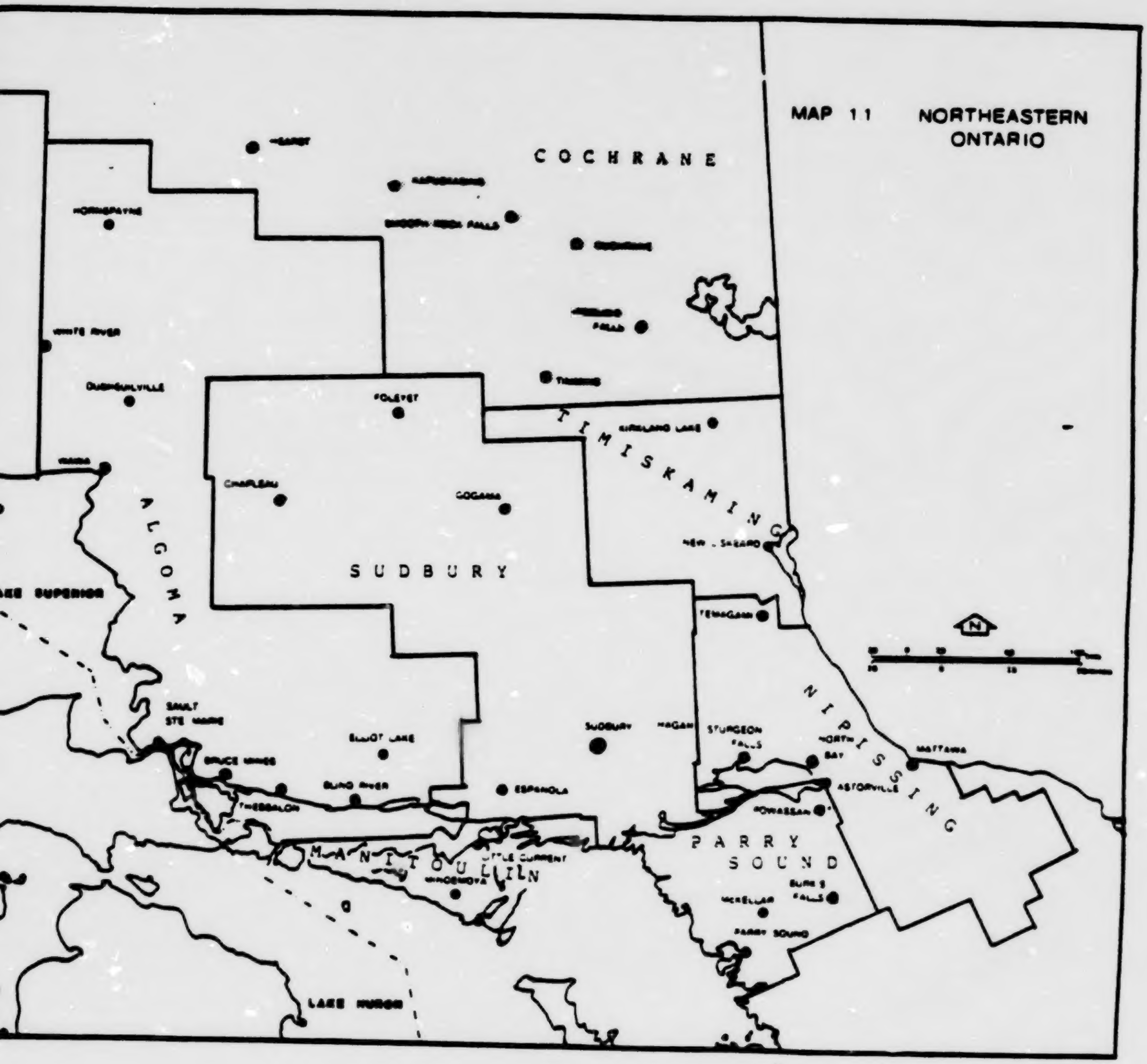
EXHIBIT 21

SUMMARY OF POSITIONS IN MENTAL HEALTH*

Mental Health System Total Population Chronic Psychiatric Group	ALGOMA 155,800 975		COCHRANE 106,700 665		MANITOULIN/SUDBURY 200,800 1,250		NIPISSING/TIMISKAMING 121,100 758		NORTHEASTERN ONTARIO 584,400 3,648		
	Have	Need	Have	Need	Have	Need	Have	Need	Have	Need	Net
ADULT COMMUNITY-BASED PROGRAMS											
Case Management	3	32-39	-	22-27	12	42-50	8	25-30	23	121-146	98-123
SIL	-	12	-	9	-	18	-	10	0	49	49
High/Medium Support Housing	3-4.5	20-25	-	15-20	-	27-33	-	18-22	3-4.5	80-100	77-95.5
Drop-In	1.5	4-8	2	4-8	-	4-8	5	4-8	8.5	16-32	7.5-23.5
Employment Programs	-	5-9	-	5-9	-	5-9	10.5	5-9	10.5	20-36	9.5-25.5
Community Mental Health	15-17	15-17	14-15	14-15	34-37	34-37	16-17	16-17	79-86	79-86	-
SUB-TOTAL	22.5-26	88-110	16-17	69-88	46-49	130-155	39.5-40.5	78-96	124-132.5	365-449	241-316.5
ADULT HOSPITAL-BASED SERVICES											
Crisis Intervention	2-3	6-8	-	6-8	2-3	8-11	-	6-8	4-6	26-35	22-29
Acute In-Patient Psychiatry	47-49	63-68	32-33	44-48	151.7	83-86	-	50-53	230.7-233.7	239-255	8.3-21.3
Geriatric Outreach	-	4-5	-	4-5	-	6-8	-	4-5	0	18-23	18-23
Ambulatory Care	5.5	20.5-25.5	0	10-15	4-5	15-20	-	15-20	9.5-10.5	60.5-80.5	51-70
Hostel	-	2-4	-	2-4	-	2-4	-	2-4	0	8-16	8-16
SUB-TOTAL	54.5-57.5	95.5-110.5	32-33	66-80	157.7-159.7	113-129	0	77-90	244.2-250.2	351.5-409.5	107.3-159.3
CHILDREN'S ACUTE PSYCHIATRY	-	13-16	-	13-16	-	26-32	-	13-16	0	65-80	65-80
CHILDREN'S COMMUNITY-BASED SERVICES	14	21-22	25	31-33	26	36-41	15.3	22.3-23.3	80.3	110.3-119.3	30-39
SUB-TOTAL: CHILDREN'S	14	34-38	25	44-49	26	62-73	15.3	35.3-39.3	80.3	175.3-199.3	95-119
ADDICTIONS SERVICES	21.2	41.2-46.2	21.5-22.5	41.5-47.5	27.5	63.5-67.5	22.1	42.1-47.1	92.3-93.3	188.3-208.3	96-115
TOTAL: SERVICE AREA	112.2-118.7	258.7-304.7	94.5-97.5	220.5-264.5	257.2-262.2	368.5-424.5	76.9-77.9	232.4-272.4	540.8-556.3	1080.1-1266.1	539.3-709.8
REGIONAL SERVICES											
Adult Psychiatry									478	245	(233)
Children's Psychiatry									127	13-16	(111-114)
TOTAL: REGIONAL									605	258-261	(344-347)
GRAND TOTAL	112.2-118.7	258.7-304.7	94.5-97.5	220.5-264.5	257.2-262.2	368.5-424.5	76.9-77.9	232.4-272.4	1145.8-1162.3	1338.1-1527.1	195.3-364.8

EXHIBIT 22

NORTHEASTERN ONTARIO: COCHRANE SERVICE AREA


MAP 11
NORTHEASTERN ONTARIO
COCHRANE
SMOOTH ROCK FALLS
FALLS
HORNEPAYNE
WHITE RIVER
DUBREUILVILLE
FOLEYET
TIMISKAMING
KIRKLAND LAKE
CHAPLEAU
GOGAMA
NEW LISKEARD
ALGOMA
SUDBURY
LAKE SUPERIOR
TEMAGAMI
N
NIPISSING
SAULT STE MARIE
ELLIOT LAKE
SUDBURY
HAGAR
STURGEON FALLS
NORTH BAY
MATTAWA
BRUCE MINES
BLIND RIVER
THESSALON
ESPANOLA
ASTORVILLE
POWASSAN
PARRY SOUND
MANITOULIN
LITTLE CURRENT
MINDEMOYA
BURK'S FALLS
MCKELLAR
PARRY SOUND
LAKE HURON

In 1981, Cochrane had a population of 96,875. This results in a population density of 0.7 residents per square kilometer. The number of Cochrane residents is projected to increase by 10% to 106,669 by year 2001. The major population centres in Cochrane are:

- Timmins with a population of 46,114 or 47.6% of all Cochrane residents;
- Kapuskasing with 12,014 residents or 12.4% of the population;
- Iroquois Falls with 6,339 or 6.5% of the population; and
- Hearst with 5,553 or 5.7% of the population.

In the Cochrane District Health Council report on mental health services, several major service centres were identified and surrounding areas were added to some of these urban centres resulting in:

- Kapuskasing service centre with 16,500;
- the Hearst service centre with 9,500;
- the Cochrane service centre with 7,500;
- the Moosonee service centre with about 4,000 residents; and
- the Smooth Rock Falls service centre with 3,500.

Differences in the areas as defined were pointed out with respect to age composition, mother tongue, etc. Alcoholism was noted as a major problem.

To residents, the area known as "North Cochrane" includes the cities of Kapuskasing, Hearst and Smooth Rock Falls while "South Cochrane" generally means Timmins/Iroquois Falls. Cochrane has the highest level of rural population and because 1 out of 3 residents lives outside an urban centre, planning for this area is particularly difficult.

Unlike the other Northeast service areas, Cochrane is largely francophone, with 48% or 46,460 residents reporting french as their mother tongue. The other 44% and 8% report english or "other" language as their mother tongue respectively. Cochrane has 3 native reserves with 2,018 residents.

Labour force participation rates show Cochrane at the average for Northeast areas with 75% of men and almost 45% of women in the labour force. This is however significantly lower than the reported 79.8% for men and 55.2% for women for the Province. Average income for men and women once again approximates the average throughout the Northeast and is better than that reported for Nipissing/Timiskaming.

Cochrane's residents have less education than anywhere else in the Northeast; 26% of residents over age 15 have less than Grade 9 schooling.

Major Mental Health Providers

Hospital Providers

As discussed in the utilization review, the major designated hospital provider in Cochrane is the St. Mary's General Hospital in Timmins. With 20 acute psychiatry beds it ranks fifth in patient days and separations and, on average, utilization levels well exceed designated bed capacity, e.g. 27 beds are used. Plans for a new Timmins and District Hospital include 60 psychiatry beds.

The current catchment area of the St. Mary's General Hospital service is primarily the Cochrane service area. Other community hospitals without designated beds but playing a significant role in psychiatric treatment include the Kapuskasing Sensenbrenner Hospital, using 6 to 7 beds on average for individuals with a psychiatric diagnosis and the Hearst Notre Dame Hospital which uses 2 to 3 beds for such care. These two hospitals in the "North Cochrane" area accounted for 362 or almost 25% of separations of Cochrane residents in 1984/85.

Separations data shows that Cochrane is fairly self-sufficient in caring for its residents' needs for hospital psychiatric services; 86.1% of Cochrane separations were from Cochrane hospitals in 1984/85. North Bay Psychiatric Hospital treated 9.4%, followed by Homewood Sanitarium which represented 2.3% of separations. Few Cochrane residents were separated from hospitals in other parts of the Northeast. It is interesting to note, however, that 40% of GP respondents to the questionnaire said they refer to NBPH while only 28% refer directly to psychiatrists at St. Mary's General Hospital.

As shown in Exhibit 23, St. Mary's General Hospital and the Kapuskasing Sensenbrenner Hospital treat the greatest percentage of individuals with schizophrenia or affective psychoses, identified in this study as the chronically disabled, the major user group. One out of 3 patients at St. Mary's was diagnosed with a neurotic disorder. Overall 26.6% of Cochrane hospital's separations are classified as "neurotic" disorders.

Alcoholism is an area in which many hospitals perform a role. Over 25% of Cochrane separations were for alcohol or drug abuse; including 40% of the separations from Lady Minto Hospital, 32% at Porcupine General and almost 30% of psychiatric separations at Moose Factory General which were for alcoholism.

Funded Community Mental Health Programs

There are a number of formally funded programs which provide services in Cochrane.

* **Mid-Step Program (Timmins)**

Located at St. Mary's General Hospital, the Mid-Step Program offers a variety of day treatment programs such as small group therapy, life skills training, community activities, relaxation exercises, music and art therapy and leisure education for groups of 8 to 10 people who meet four days per week.

* **Lifeline Program (Timmins)**

The Canadian Mental Health Assocation, Timmins Branch first established the drop-in program for adults who are chronically mentally ill. The program is designed with strong one-to-one volunteer support and to assist individuals to re-adjust into community living. Social recreation provides activities and life skills training.

* **Minto Counselling Centre (Cochrane)**

This is the community mental health clinic operated by Lady Minto Hospital. Direct services provided by the organization include assessments, short-term/long-term counselling, after-care services, referrals to other agencies and psychiatric consultation on a once-a- month basis through Homewood Sanitarium psychiatrists.

Agency consultations and education are also provided. Close liaison with other agencies has been established to ensure local co-ordination of services.

The target group for services are adults, and some adolescents 16 to 18 years of age who live independently.

EXHIBIT 23

COCHRANE
1984/85 SEPARATIONS AS % OF HOSPITAL TOTAL

		ST. MARY'S GENERAL	HEARST NOTRE DAME	KAPUSKASING SENSENBRENNER	PORCUPINE GENERAL	BINGHAM MEMORIAL	SMOOTH ROCK FALLS	LADY MINTO	ANSON GENERAL	MOOSE FACTORY	TOTAL COCHRANE
290	SENILE & PRE-SENILE	2.7	0.0	0.0	5.9	4.0	0.0	1.1	3.6	0.0	1.8
291	ALCOHOL PSYCHOSIS	4.0	0.0	0.7	2.9	0.0	0.0	1.6	0.0	6.5	2.6
292	DRUG PSYCHOSIS	0.8	0.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.4
293/4	OTHER ORGANIC PSYCHOSIS	0.8	0.0	0.7	0.0	0.0	0.0	1.6	2.4	0.0	0.8
295	SCHIZOPHRENIA	12.1	4.3	11.9	4.4	12.0	2.9	6.0	3.6	9.8	9.6
296	AFFECTIVE PSYCHOSIS	13.6	6.5	7.8	4.4	0.0	2.9	5.5	1.2	3.3	8.7
297	PARANOID STATE	1.8	1.1	0.7	0.0	0.0	0.0	0.5	0.0	0.0	1.0
298/9	OTHER PSYCHOSIS	2.0	3.2	3.0	8.8	4.0	0.0	2.7	4.8	4.3	3.0
300	NEUROTIC DISORDER	32.9	21.5	26.0	20.6	44.0	26.5	17.5	25.0	12.0	26.6
301	PERSONALITY DISORDER	2.3	1.1	4.5	0.0	0.0	0.0	6.0	0.0	4.3	2.9
303	ALCOHOLISM	13.8	22.6	10.4	32.4	16.0	20.6	39.9	31.0	27.2	19.9
304/5	DRUG DEPENDENCY & ABUSE	1.8	15.1	9.7	1.5	12.2	8.8	7.7	2.4	8.7	5.7
308	ACUTE REACTION TO STRESS	0.5	0.0	0.7	4.4	0.0	0.0	0.0	0.0	3.3	0.8
309	ADJUSTMENT REACTION	1.8	3.2	3.0	0.0	4.0	0.0	0.5	0.0	8.7	2.2
313	EMOTIONAL DISTURBANCE CHILDHOOD & ADOLESCENCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
302/6/7/10/11/12/16	OTHER NON-PSYCH DISORDER	8.4	20.4	20.8	14.7	4.0	35.3	8.7	26.2	9.8	13.5
314	HYPERKENETIC SYNDROME	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
315	DELAY IN DEVELOPMENT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	0.1
317/8/9	MENTAL RETARDATION	0.5	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.3
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SOURCE: MINISTRY OF HEALTH DATA DEVELOPMENT BRANCH

- **Sensenbrenner Community Mental Health Services (Kapuskasing)**

  Operated by the Mental Health Advisory Committee, this service is responsible to the Sensenbrenner Hospital Board. It is funded as a community mental health clinic, offering a variety of programs such as short-term and long-term counselling, assessment and consultation services, public education, and community development. Offices are located in Kapuskasing, Hearst and Smooth Rock Falls, serving a population of 27,500.

- **Moosonee Area Mental Health Services**

  Adult mental health needs are met locally at the Moose Factory Hospital as funded by the Federal Government. The service (with travelling psychiatrist support from the University of Western Ontario) is designed to meet the needs of the Treaty Indians.

Addictions Services

There are a number of addictions services available in the Cochrane service area:

- **Maison Renaissance Inc. (Hearst)**

  Maison Renaissance offers a 28-day residential alcohol and drug rehabilitation program for francophone men and women based on an Alcoholics Anonymous model. It has 7 beds available.

- **North Cochrane Addiction Services, Inc./Service de Toxicomarie Inc., Cochrane Nord (Head office: Kapuskasing)**

  This program offers alcohol and drug assessment and referral services. Its primary role is to assess the individual's needs, prepare a treatment plan and refer the individual to appropriate treatment centres and/or support groups. The program also provides public education and community development.

- **Alcoholism and Drug Addiction Research Foundation (Timmins)**

  The Alcoholism and Drug Addiction Research Foundation plays a major role in activities related to the promotion of mental health, referrals to appropriate agencies, planning and co-ordination and research activities.

Other players in addictions services include the Cor Jesu program in Timmins, and the federally-funded National Native Alcohol and Drug Abuse Program in Moose Factory.

Children's Services

The major children's services in the Cochrane service area include:

- **South Cochrane Child and Youth Services (children's mental health centre);**
- **Child and Youth Development Centre in Kapuskasing (children's mental health centre);**
- **Moosonee Children's Mental Health Service; and**
- **Porcupine and District Children's Aid Society.**

* * * * *

As reported in the mental health questionnaire, many other groups/agencies have roles in mental health, such as Boards of Education, MCSS-funded programs such as the Centre de Counselling Familial de Timmins, Inc., and Habitat Interlude Crisis Housing, plus churches, Public Health Units, and the Cochrane Timiskaming Resource Centre.

Planning Bodies

Cochrane has a District Health Council with an active mental health sub-committee. As well, the Ministry of Correctional Services and the Muskegog Cree Council, Constance Lake Band, Moose Factory Band all report that they play an important role in planning and delivery of mental health services for special groups. Local ACFO groups also perform some promotion and prevention activities. This points to the need to integrate such groups into the CMHMB which is developed for Cochrane.

Strengths and Weaknesses

Cochrane had a response rate of 34% of GPs and 44% of hospitals, community-based agencies and other groups which received questionnaires or were interviewed. In Cochrane, one out of 4 GPs reported that they provide a mental health service. This is much higher than the 16% in Manitoulin/Sudbury or Nipissing/ Timiskaming and indicates a higher level of GP involvement in Cochrane. Some of the services offered by GPs include consultation, family/child psychotherapy, and adolescent depression management.

Most notable in Cochrane is that 46% of GPs reported that currently there are no strengths in mental health services; 25% reported nurses and social workers to be strengths and 20% reported local physicians to be strengths. There was not much consensus amongst 53 providers and agencies who responded as to strengths; 19% or 10 groups indicated that good communications were strengths and another 11% or 6 groups cited the mental health association as a strength.

There were many more weaknesses reported by respondents. Agencies, etc. reported lack of psychiatrists and other professionals to be the two greatest weaknesses. Some of the other weaknesses noted were:

- shortage of beds;
- lack of communication and co-ordination;
- lack of children's services;
- lack of bi-lingual services; and
- lack of public education.

The lack of facilities, sheltered workshop and housing were also noted as gaps in service. GPs were generally in agreement on the weaknesses with "lack of psychiatrists" reported by 39% of GPs. However, one out of 3 GPs reported unclear provider roles, lack of communication and co-ordination between current providers as the second greatest weakness to be addressed in their community. It should be noted that, since the time of the questionnaire, a number of new psychiatrists have been recruited to Timmins.

The recent Cochrane District Health Council Task Force on Mental Health Services considered 3 areas as priorities for implementation:

- "the lack of adequate mental health professionals including psychiatrists, social workers and psychologists for both children's and adult's services;
- the lack of institutional and community support services for chronically disabled psychiatric patients; and

- the lack of institutional services for psychiatrically disturbed children and adolescents."

These areas are addressed in the model application which follows.

Application of the Model

As shown in the following Exhibit 24, the Cochrane population base which is used is 106,700 for a model which should be fully implemented by year 2001. The chronic population/major users of mental health services is estimated to be 665 based on 6.25 chronic users per 1,000 general population.

The regional psychiatry services are shown in the model for Cochrane as residents will have access to these highly specialized services where required. Otherwise, the services which are identified within the service area should be sufficient generally to meet the needs of the population.

Case Management

Currently a range of groups perform the case management function. It is a highly fragmented responsibility assumed by key players such as public health nurses and a range of funded community mental health programs. The full-time case managers proposed under this model will supplement current functions with 22 to 27 new positions required. Such case managers should be distributed across Cochrane, considering the large number of francophones in the area. Cities/towns such as Cochrane, Hearst, Smooth Rock Falls and Iroquois Falls should all have case managers who will work directly with the designated psychiatric services which will be established in North Cochrane and at the new Timmins District Hospital.

Based on demographic data it is recommended that 11 to 13 (approximately 50%) of the case managers be francophone or fluently bi-lingual and that 4 case managers have native backgrounds and be capable of providing necessary linkages to the reserves and address specific needs of native people living in cities.

Supportive Independent Living Program (SIL)

There is nothing formalized as suggested for this program. Some life skills are taught by workers in the St. Mary's General Mid-Step Program in Timmins and this could be a starting place for developing a program for Cochrane. Nine full-time SIL workers are recommended including 4 francophones and 1 native SIL worker.

COCHRANE MENTAL HEALTH SERVICES MODEL IN YEAR 2001
GENERAL POPULATION BASE: 106,700
CHRONIC PSYCHIATRIC POPULATION: 665

	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
REGIONAL PSYCHIATRIC SERVICES			
1. ADULT SECURE UNIT	REGIONAL SERVICE - 24 BEDS	24 BEDS WITH STAFF AT N.B.P.H.	
2. SPECIALIZED ADULT DEVELOPMENTALLY HANDICAPPED UNIT	REGIONAL SERVICE - 26 BEDS	NOTHING FORMALIZED IN NORTHEAST OR NORTHWEST ONTARIO, HOWEVER THERE ARE 18 PATIENTS IN N.B.P.H. SPECIAL REHABILITATION BEDS WHO MAY QUALIFY	26 BED DEVELOPMENTALLY HANDICAPPED UNI WITH 27-30 STAFF; POSSIBLE MIX 60-70% PROFESSIONAL RN'S
3. ADULT CONTINUING CARE UNIT	REGIONAL SERVICE - 60 BEDS	SPECIAL REHABILITATION UNITS WITH 154 BEDS AND STAFF AT N.B.P.H.	
4. CHILDREN'S IN-PATIENT UNIT	REGIONAL SERVICE - 10 BEDS	32 BEDS AT SUDBURY ALGOMA HOSPITAL SERVING NORTHEAST/NORTHWEST ONTARIO, PARRY SOUND, MUSKOKA AND BEYOND	REFOCUS OF THE 10 CHILDREN'S BEDS ON NORTHEAST ONTARIO ONLY
ESSENTIAL COMPONENTS OF THE MENTAL HEALTH SYSTEM IN THE SERVICE AREA			
5. ADULT COMMUNITY-BASED SERVICES			
- CASE MANAGEMENT SERVICES	22-27 CASE MANAGERS	NO FORMALLY ESTABLISHED OR FUNDED "CASE MANAGEMENT" PROGRAM - FRAGMENTED FUNCTION PERFORMED BY A RANGE OF GROUPS: PUBLIC HEALTH NURSES, V.O.N. LIFELINE PROGRAM - TIMMINS ST. MARY'S GENERAL MID-STEP PROGRAM COCHRANE MENTAL HEALTH SERVICES (MINTO COUNSELLING) KAPUSKASING MENTAL HEALTH SERVICE MOOSE FACTORY HOSPITAL HEALTH CENTRE JAMES BAY GENERAL HOSPITAL, OUT-PATIENT SERVICE PORCUPINE HOME CARE PROGRAM	22-27 CASE MANAGERS

EXHIBIT 24

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- SUPPORTIVE INDEPENDENT LIVING (S.I.L.) PROGRAM	9 S.I.L. WORKERS	SOME LIFE SKILLS TAUGHT AT ST. MARY'S MID-STEP PROGRAM	9 S.I.L. WORKERS
- HIGH/MEDIUM SUPPORT HOUSING	13 BEDS WITH 15-20 TOTAL STAFF	NOTHING	13 BEDS (IN 1 OR 2 HOMES) WITH 15-20 ADDITIONAL STAFF
- DROP-IN CENTRES	2-4 CENTRES WITH 4-8 TOTAL STAFF	CMHA/TIMMINS LIFELINE PROGRAM OFFERS SOCIAL AND RECREATION PROGRAMS - 2 STAFF	1-3 ADDITIONAL PROGRAMS WITH 2-6 ADDITIONAL STAFF
- EMPLOYMENT PROGRAMS			
. SUPERVISED WORK SITES	1-2 WORK SITES WITH 3-6 TOTAL STAFF	NOTHING	1-2 WORK SITES WITH 3-6 TOTAL STAFF
. JOB DEVELOPMENT PROGRAM	2-3 JOB SUPERVISORS	NOTHING	2-3 JOB SUPERVISORS
. EMPLOYMENT COUNSELLING AND ASSISTANCE PROGRAMS	ACCESS TO PROGRAMS FOR HIGH POTENTIAL PEOPLE	CANADA EMPLOYMENT CENTRES BOARDS OF EDUCATION COMMUNITY COLLEGE PROGRAMS FAMILY COUNSELLING CENTRES MARCH OF DIMES REHABILITATION (FOR PHYSICALLY DISABLED) NATIVE BANDS JAMES BAY EDUCATION CENTRE	
- COMMUNITY MENTAL HEALTH PROGRAMS	BROAD RANGE OF COUNSELLING, EDUCATION, PREVENTION AND SELF-HELP PROGRAMS AS APPROPRIATE TO MEET LOCAL NEEDS.	FUNCTIONS PERFORMED BY A BROAD RANGE OF GROUPS: TELECARE - TIMMINS MID-STEP PROGRAM - ST. MARY'S - 5 STAFF	THIS COMPONENT IS DIFFICULT TO QUANTIF IN THE SENSE OF "NEED" WHICH APPEARS UNLIMITED - PRIORITIES MUST BE DETERMINED BY THE SERVICE AREA

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- COMMUNITY MENTAL HEALTH PROGRAMS (CONT'D)		SENSENBRENNER COMMUNITY MENTAL HEALTH CENTRE - 4-5 STAFF MINTO COUNSELLING CENTRE - COCHRANE - 3 STAFF FAMILY COUNSELLING CENTRE - TIMMINS - 2 STAFF SENSENBRENNER SOCIAL WORKERS OUTREACH TO HEARST/SMOOTH ROCK FALLS PUBLIC HEALTH NURSES, V.O.N. GP'S ACFO COMMUNITY HOSPITALS SOME CHURCHES PSYCHIATRIC COMMUNITY ASSOCIATION - TIMMINS ASSOCIATION FOR THE MENTALLY RETARDED NATIVE GROUPS	
6. ADULT HOSPITAL-BASED SERVICES			
- CRISIS INTERVENTION PROGRAM	1-2 FORMAL PROGRAMS WITH 6-8 TOTAL STAFF	ROLE PERFORMED BY A RANGE OF GROUPS: PUBLIC HEALTH NURSES, V.O.N. ASSOCIATIONS FOR THE MENTALLY RETARDED COMMUNITY MENTAL HEALTH PROGRAMS CHILDREN'S MENTAL HEALTH SERVICES C.A.S. OPP GP'S	TIMMINS AND DISTRICT HOSPITAL (AND THE NORTH COCHRANE HOSPITAL) TO ESTABLISH PROGRAMS WITH 6-8 TOTAL STAFF TRAINING FOR COMMUNITY HOSPITAL STAFF AND OTHER AGENCIES WITH STRONG NETWORKING AND COMMUNICATIONS

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- CRISIS INTERVENTION PROGRAM (CONT'D)		FAMILY RESOURCE CENTRE - MATHESON HOMES FOR THE AGED, NURSING HOMES SOCIAL SERVICES DEPARTMENT COMMUNITY HOSPITALS PSYCHIATRIC COMMUNITY ASSOCIATION VARIOUS SELF-HELP GROUPS TELECARE - TIMMINS HABITAT INTERLUDE NATIVE REPRESENTATIVES	
- "ACUTE" PSYCHIARTY BEDS	43 BEDS WITH 44-48 TOTAL STAFF	20 BEDS AT ST. MARY'S HOSPITAL, 32-33 STAFF, 2 BEDS DESIGNATED AT HEARST NOTRE DAME HOSPITAL	13 BEDS AT THE NEW TIMMINS DISTRICT HOSPITAL WITH 12-15 STAFF 10 BEDS DESIGNATED AT A NORTH COCHRANE HOSPITAL
- GERIATRIC OUTREACH PROGRAM	4-5 STAFF	NOTHING FORMALIZED	4-5 STAFF
- AMBULATORY CARE SERVICES	2 FORMAL SERVICES TO SUPPORT EACH IN-PATIENT FUNCTION WITH 10-15 TOTAL STAFF	VARIOUS HOSPITAL PROGRAMS WITH THIS AS A FUNCTION AND "ONE" OF ITS ROLES: MID-STEP MINTO COUNSELLING CENTRE SENSENBRENNER COMMUNITY MENTAL HEALTH SERVICES	2 SERVICES WITH A RANGE OF TREATMENT PROGRAMS AND 10-15 TOTAL STAFF
- HOSTEL SERVICE	1 OR 2 HOSTELS WITH 2-4 TOTAL STAFF	NOTHING	1-2 HOSTELS WITH 2-4 TOTAL STAFF

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
7. CHILDREN'S ACUTE PSYCHIATRY BEDS	10 ACUTE CARE BEDS WITH 13-16 STAFF	NOTHING	10 BEDS WITH 3.5 STAFF ON DAY/EVE; 1 RN, 2 CHILD CARE, 0.5 RECREATION THERAPIST; 1 RN AND CHILD CARE WORKER AT NIGHT (13-16 TOTAL STAFF)
8. CHILDREN'S MENTAL HEALTH CENTRE	31-33 TOTAL STAFF	SOUTH COCHRANE CHILD AND YOUTH SERVICES - 14 STAFF CHILD AND YOUTH DEVELOPMENT CENTRE IN KAPUSKASING - 10 STAFF MOOSONEE CHILDREN'S MENTAL HEALTH SERVICES - 1 WORKER	ESTABLISH PUBLIC HEALTH NURSES WITHIN THE SCHOOL SYSTEM - 6-8 SCHOOL-BASED MENTAL HEALTH NURSES
9. PSYCHIATRISTS	10 PSYCHIATRISTS	4 LOCAL PSYCHIATRISTS AND SUPPORT FROM TRAVELLING PSYCHIATRISTS E.G. LONDON	6 PSYCHIATRISTS
10. ADDICTIONS SERVICES PROGRAM COMPONENTS INCLUDE: - HEAD OFFICE - ASSESSMENT, REFERRAL AND CASE MANAGEMENT - DAY TREATMENT PROGRAM - OUT-PATIENT PROGRAM - AFTER-CARE PROGRAM - DETOX BEDS - SUPERVISED RESIDENCE - COMMUNITY ADDICTIONS SERVICES WORKERS	ONE COMPREHENSIVE PROGRAM PER SERVICE AREA TO COMPLEMENT AND ENHANCE EXISTING SERVICES	NOTHING EXISTS IN THIS FORM CURRENTLY	SUDBURY ALGOMA PILOT FOLLOWED BY THE TAILORING AND ESTABLISHMENT OF A SERVIC WITH 20-25 STAFF PLUS SPACE, EQUIPMENT AND DETOX BEDS

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	**2001 REQUIREMENTS**	**CURRENT SERVICES**	**NET ENHANCEMENTS/ADDITIONS**
10. ADDICTIONS SERVICES (CONT'D) EXISTING SERVICES		MAISON RENAISSANCE - HEARST - 3.5 STAFF NORTH COCHRANE ADDICTION SERVICES - COUNSELLING - 3 STAFF ALCOHOLISM AND DRUG ADDICTION RESEARCH FOUNDATION - TIMMINS - 3 STAFF NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM - MOOSE FACTORY (FEDERAL) COR JESU - TIMMINS, 5-6 STAFF ADDICTION RESEARCH - SOUTH COCHRANE CASE MANAGEMENT SERVICE, 3 STAFF SERVICE DE TOXICOMARIE - KAPUSKASING, 4 STAFF	LINKAGES TO THE COMPREHENSIVE PROGRAM APPROPRIATE

High/Medium Support Housing

The establishment of housing has been a historic problem in the city of Timmins, where the only designated psychiatric treatment beds exist at St. Mary's General Hospital.

This model requires one or two homes with 13 beds in the Cochrane service area. These beds may or may not need to be in Timmins where zoning has been a problem. Such services could be located in North Cochrane, with back-up from a North Cochrane hospital which develops a designated service and comprehensive ambulatory care services. The placement of these beds will be determined by the CMHMB and in light of zoning issues.

Drop-In Centres

The Lifeline Program in Timmins offers social and recreational programs and is the only drop-in centre in the Cochrane service area. This program should continue, and other areas with identified populations of chronically mentally ill individuals should begin to establish programs. A range of 2 to 4 centres is suggested to allow the development of such new programs.

Employment Programs

Cochrane requires a range of "employment" programs for individuals with mental health problems. There is a need for 1 or 2 work sites which might take the form of a sheltered workshop or be creatively developed as a program of the drop-in centre (similar to the Progress Place model). A work site will likely be required in Timmins as a priority.

As well, a job development program is required with 2 to 3 staff. For high potential candidates, relationships should be developed between mental health workers and existing organizations such as Canada Employment Centres, Boards of Education, community college programs, the March of Dimes program and the Cochrane Vocational Rehabilitation program. As well, native case managers should work directly with the Bands and James Bay Education Centre to develop additional programs for native residents with identified mental health problems.

Community Mental Health Centres

Current staff who perform functions of counselling, education, prevention and self-help programs are preserved under the model. The CMHMB will need to consider these programs in the context of the specific target group served and in light of expected outcomes and results.

As suggested for children's mental health centres, clearly defined plans are required to ensure that resources are utilized in a cost-effective manner. Demand for such services could be infinite and it will be the responsibility of the CMHMB to work with the DHC to prioritize requests for new programs in light of what other groups and volunteer agencies are doing.

As noted, there is a whole range of programs, including MCSS-funded and volunteer agencies, which are involved in community mental health programs.

Crisis Intervention Programs

There are no formally-funded hospital-based crisis intervention services in Cochrane. The role is performed by many groups and agencies throughout the service area. Hospitals, public health nurses, community mental health programs, children's service providers, the police and GPs all report that they deal with crises. There are some programs in place to deal with the acute housing needs of women and their children including the Family Resource Centre in Matheson and Habitat Interlude in Kapuskasing.

It is recommended that 1 or 2 formal programs be developed in Cochrane, beginning at St. Mary's General Hospital. A service may also be developed at the North Cochrane hospital which becomes the other designated provider of psychiatry services.

The staff of formal programs should take leadership roles in educating other hospital staff throughout the service area to deal with mental health and other crises. They could also assist mental health workers in small communities to develop policies and procedures for dealing with crises.

As shown in Exhibit 24, many providers and agencies deal with mental health crises and could benefit from strong working relationships with formal crisis programs.

Acute Psychiatry Beds

There are 20 psychiatry beds at St. Mary's General Hospital. The service area requires a total of 43 beds under this model, with 33 beds recommended for the new Timmins District Hospital and a 10-bed service recommended at a North Cochrane facility.

Geriatric Outreach

This program requires 4 to 5 professional staff assisted by a psychiatrist. The program will likely be based out of the

St. Mary's General Hospital or the new Timmins District Hospital with outreach provided as workers travel to smaller communities to provide services. Another option is that one geriatric specialist may be placed at a North Cochrane hospital with a designated service.

Ambulatory Care Services

Such services are recommended to provide active treatment programs to support the acute psychiatry in-patient unit (at St. Mary's General/new hospital) and at the selected North Cochrane hospital. They will be available to patients who travel in to receive services and those staying at the the hostel.

The Mid-Step Minto Counselling Centre and Sensenbrenner Community Mental Health Services currently provide a few of the types of services which might be offered in a comprehensive ambulatory service.

Hostel

One or two hostels are required to accommodate patients involved in ambulatory care who may travel a distance for care, yet not require hospitalization.

Children's Acute Psychiatry Beds

There are no such beds in Cochrane currently. Ten beds with staff are recommended and will likely be developed at/or near the Timmins Hospital. As discussed previously this service should result in a major improvement to services for children in the service area. A child psychiatrist or psychiatrist with experience in working with children should be recruited in order to offer this service.

Children's Mental Health Centres

The South Cochrane Child and Youth Service and the Child and Youth Development Centre in Kapuskasing are important elements and strengths in the current mental health system. Enhancements to the services of children's mental health centres in all service areas are suggested with the introduction of public health nurses working in mental health within the school system.

Psychiatrists

Based on a standard of 1 psychiatrist per 10,000 general population the Cochrane area has an extreme shortage of psychiatrists. There are only 4 psychiatrists practising in Timmins with other support provided by travelling psychiatrists from London. Another 6 psychiatrists would be required to bring Cochrane to a target of 10. This shortage was identified as a major weakness in current services. However it should be noted that the model proposed is not dependent upon psychiatrists and recommends GPs be trained and developed to deal with the supportive, on-going maintenance needs of chronic psychiatric disabled individuals in their communities. At least half of psychiatrists should be fluently bi-lingual or francophone.

Addictions Services

Cochrane has several addictions services which offer assessment and treatment programs such as Maison Renaissance in Hearst, North Cochrane Addictions services, Cor Jesu and the National Native Alcohol and Drug Abuse Program. The Sudbury Algoma proposed model offers a comprehensive range of treatment options which could be introduced in Cochrane to complement current services. Such a service might be based in Timmins. Half of all positions should be filled with francophone workers.

Implementation Considerations

Providers and agencies in Cochrane suggested the following major obstacles to be addressed in implementing a new mental health services model. These are ranked in order of respondent frequency.

- 50% said lack of funding;
- 40% said lack of personnel;
- 30% report distance and isolation;
- 17% thought lack of communication to be a problem; and
- 17% said lack of facilities.

Some of the major implementation activities which must take place in Cochrane are:

- establishment of a CMHMB to deal with traditional rivalries and competition between communities services and to strengthen communication/co-operation between agencies and providers;
- integration of current mental health services under the CMHMB while preserving existing strengths;
- working relationships must be established with native groups and federal representatives (Department of

Northern Affairs) to jointly address the special mental health needs of natives;

- education and promotion of the model to prepare the public for the model and its new service components.
- planning and construction of new beds at St. Mary's General or the new Timmins District Hospital;
- development of an acute psychiatry service at a North Cochrane hospital with ambulatory care, hostel and crisis intervention as appropriate;
- planning of a children's acute psychiatry service and recruitment of children's experts;
- overall redefinition of treatment and accommodation functions by providers to match the requirements of the model;
- establishing appropriate levels of housing to meet the needs of Cochrane residents - if Timmins is the preferred location, the issue of zoning must be addressed;
- recruitment and retention of psychiatrists, at least half of whom should be french speaking;
- specific recruitment of additional mental health workers and specifically case managers and SIL workers who have francophone/native backgrounds who must be redeployed in areas with the greatest need; in total, by year 2001, 110 to 130 or 50% of workers should be fluently bilingual or francophone and there should be an estimated 25 to 30 native health workers;
- a transportation study will be necessary in Cochrane to determine costs within this service area to ensure access to services by all residents as Cochrane is three times the size of other service areas.

* * * * *

As shown in Exhibit 21, Summary of Positions in Mental Health, Cochrane currently has 95 to 98 mental health positions and requires 220 to 265 in order to implement the proposed model. To this end, staffing of mental health services in Cochrane will almost triple, costing $7.5 to $9 million a year for staffing.

THE MANITOULIN/SUDBURY SERVICE AREA

As shown in Exhibit 25, the Manitoulin/Sudbury service area covers a broad geographic area of 49,561 square miles. It is almost equal in size to Algoma but has a significantly larger population base. Manitoulin/Sudbury is at the centre of Northeast Ontario, surrounded by Algoma, Cochrane, Timiskaming and Nippising.

In 1981, Manitoulin/Sudbury had a population of 197,848. This results in a population density of 4.0 residents per square kilometer. The number of Manitoulin/Sudbury residents is projected to remain fairly constant, increasing about 1% and to 200,100 by year 2001. The major population centres in Manitoulin/Sudbury are:

- Sudbury (City) with a population of 91,829 or 46.4% of Manitoulin/Sudbury residents;
- Valley East with 20,433 or 10.3% of residents;
- Rayside - Balfour represents 15,017 or 7.6% of residents; and
- Nickle Centre with a population of 12,318 or 6.2% of residents.

Some of the smaller centres (over 5,000 population) include Walden, Onaping Fallings and Espanola. Overall, 75% to 80% of the total population live in the Regional Municipality of Sudbury. This is the only service area in Northeast Ontario with such a high concentration of residents in one fairly localized area.

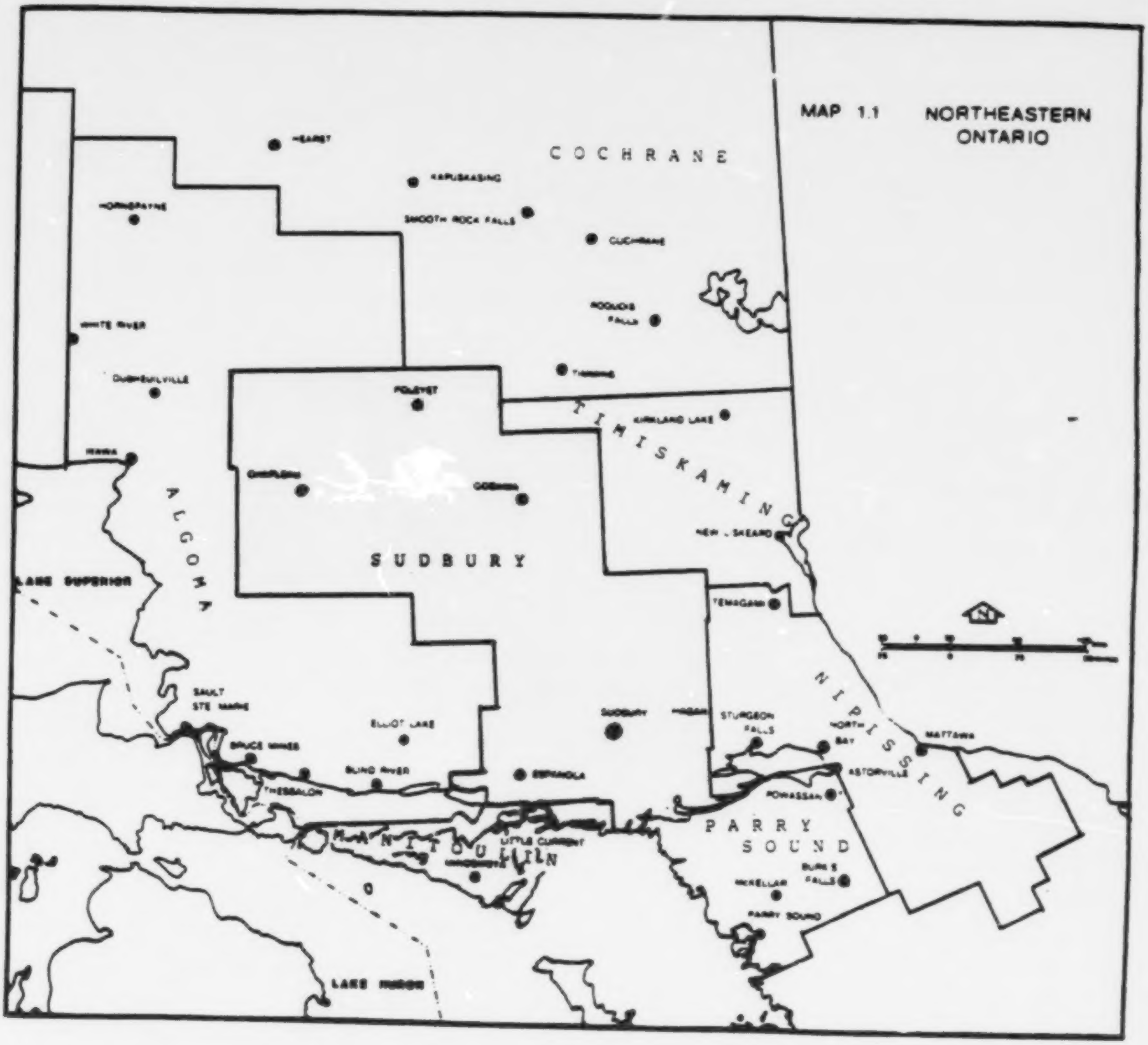
Manitoulin/Sudbury is primarily anglophone as 60% of residents report English as their mother tongue, and approximately 29% are francophone, which is a similar percentage as that reported for Nipissing/Timiskaming. Another 10.9% of residents report "other" language as their mother tongue. Manitoulin Island has a high concentration of native individuals and Manitoulin/ Sudbury has a total of 11 reserves with 3,513 native residents.

Manitoulin/Sudbury labour force participation rates approximate the average for Northeast Ontario with 75% of men and 45.9% of women in the labour force. Average income for men and women is also near the average reported for the Northeast.

Manitoulin/Sudbury is also shown to be at the average educational level reported for the Northeast as 22.4% of individuals over age 15 have less than Grade 9 schooling.

EXHIBIT 25

NORTHEASTERN ONTARIO: MANITOULIN/SUDBURY SERVICE AREA


MAP 1.1
NORTHEASTERN ONTARIO
COCHRANE
HEARST
KAPUSKASING
HORNEPAYNE
SMOOTH ROCK FALLS
COCHRANE
IROQUOIS FALLS
TIMMINS
WHITE RIVER
DUBREUILVILLE
FOLEYET
KIRKLAND LAKE
TIMISKAMING
WAWA
CHAPLEAU
GOGAMA
ALGOMA
NEW LISKEARD
SUDBURY
LAKE SUPERIOR
TEMAGAMI
NIPISSING
SAULT STE MARIE
SUDBURY
HAGAR
STURGEON FALLS
NORTH BAY
MATTAWA
ELLIOT LAKE
BRUCE MINES
BLIND RIVER
ESPANOLA
ASTORVILLE
THESSALON
POWASSAN
PARRY SOUND
MANITOULIN
LITTLE CURRENT
BURK'S FALLS
McKELLAR
PARRY SOUND
LAKE HURON

Major Mental Health Providers

Hospital Providers

As discussed in the utilization review, the major designated hospital providers are the Sudbury Algoma Hospital (SAH) and the Sudbury General Hospital. SAH is ranked first in annual separations and second in annual patient days behind NBPH. Sudbury General is ranked fourth in separations and in-patient days amongst other Northeast hospitals which provide psychiatric care.

In the Manitoulin/Sudbury area, it is these two providers which handle the vast majority of admissions/separations for acute psychiatric care and also have taken leadership in the development of day treatment, community-based clinics and the introduction of other mental health services.

As discussed previously, the SAH has 65 adult acute care beds and is a specialized psychiatric facility which also operates the regional children's services. Sudbury General Hospital has a 36-bed psychiatry service as one of its many hospital services.

Separations data shows that Manitoulin/Sudbury is very self sufficient in treating its residents. In 1984/85, 92.6% of residents from Sudbury were treated in the service area, with only 64 individuals or 3.5% of separations from the NBPH. The number separated from NBPH is almost as many as were separated from other Northeast hospitals.

A small number (less than 1% of total separations in Manitoulin/ Sudbury) came from Manitoulin Island. Most were separated at the Little Current Hospital, 66 in total. This is where many residents are first stabilized and then referred to one of the two Sudbury services.

Overall, 92% of Manitoulin/Sudbury residents receive care in the Service Area. Exhibit 26, shows a summary of hospitals in the area and the mix of diagnostic groups treated. Of all separations from Manitoulin/Sudbury hospitals, the largest diagnostic category is 19.3% for neurotic disorders. It is the SAH and Sudbury General which treat the highest percentage of schizophrenics and individuals with affective psychosis, identified in this study as the major user group. Almost 16% of psychiatric separations were for alcoholism and drug dependency and abuse.

Funded Community Mental Health Programs

There are three formally funded programs which provide mental health services in Manitoulin/Sudbury.

* **Crisis Intervention Program (Sudbury General Hospital)**

  This program provides a comprehensive assessment, consultation and referral service to the adult population of the Sudbury area. Generally, the program offers a short-term service with referral links to appropriate community agencies and/or in-hospital services.

* **Psychiatric Day Care Program (Sudbury General Hospital)**

  The objective of this program is to treat and rehabilitate patients disabled by psychiatric problems in an economical and effective manner. People with chronic mental health problems spend the day at the centre and return home at night. They have access to the hospital resources, including individual and group counselling, occupational and relaxation therapy as well as marital counselling.

* **Community Mental Health Clinics (Sudbury Algoma Hospital)**

  This program consists of five community mental health clinics staffed by multi-disciplinary workers focusing on clinical and prevention interventions and includes case management for a number of individuals. There is a central team with clinics in East Algoma, Nadmadwin, Sudbury East, Espanola, Manitoulin Island and Chapleau. The East Algoma clinic is shown in the model applications for Algoma as the service is provided in Elliot Lake.

* **Depression Management and Suicide Prevention Program (Manitoulin)**

  This is the small crisis intervention program at the Manitoulin Mental Health Clinic primarily designed to provide early case identification, prevention, promotion, with some counselling services for natives. Referrals to the hospital psychiatry services in Sudbury are made as required.

EXHIBIT 26

MANITOULIN/SUDBURY
1984/85 SEPARATIONS AS % OF HOSPITAL TOTAL

		SUDBURY LAURENTIAN	SUDBURY GENERAL	SUDBURY MEMORIAL	CHAPLEAU	LITTLE CURRENT	ESPANOLA GENERAL	SUDBURY ALGOMA	TOTAL MANITOULIN/ SUDBURY
290	SENILE & PRE-SENILE	7.7	2.1	1.4	0.0	0.0	0.0	1.9	1.9
291	ALCOHOL PSYCHOSIS	3.8	3.4	7.0	3.3	7.0	2.7	1.1	2.5
292	DRUG PSYCHOSIS	0.0	1.0	0.0	0.0	0.0	0.0	0.9	0.8
293/4	OTHER ORGANIC PSYCHOSIS	0.0	1.0	0.0	0.0	5.6	0.0	1.4	1.2
295	SCHIZOPHRENIA	0.0	12.0	0.0	4.9	2.8	14.9	21.1	15.4
296	AFFECTIVE PSYCHOSIS	0.0	20.7	4.2	8.2	2.8	1.4	10.7	13.0
297	PARANOID STATE	0.0	2.9	0.0	0.0	1.4	1.4	1.7	1.9
298/9	OTHER PSYCHOSIS	7.7	2.1	1.4	0.0	11.3	5.4	2.3	2.7
300	NEUROTIC DISORDER	30.8	21.7	35.2	49.2	14.1	12.2	15.0	19.3
301	PERSONALITY DISORDER	1.9	6.3	1.4	0.0	0.0	0.0	10.6	7.5
303	ALCOHOLISM	1.9	6.1	31.0	13.1	9.9	17.6	16.4	12.7
304/5	DRUG DEPENDENCY & ABUSE	1.9	2.9	4.2	0.0	25.4	6.8	1.9	3.2
308	ACUTE REACTION TO STRESS	0.0	2.7	0.0	0.0	2.8	0.0	5.7	3.9
309	ADJUSTMENT REACTION	0.0	4.9	0.0	0.0	5.6	0.0	2.8	3.2
313	EMOTIONAL DISTURBANCE CHILDHOOD & ADOLESCENCE	0.0	0.0	0.0	0.0	1.4	0.0	0.8	0.4
302/6/7/10/11/12/16	OTHER NON-PSYCH DISORDER	38.5	10.0	12.7	21.3	8.5	37.8	5.4	9.8
314	HYPERKENETIC SYNDROME	1.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0
315	DELAY IN DEVELOPMENT	3.8	0.0	0.0	0.0	0.0	0.0	0.0	0.1
317/8/9	MENTAL RETARDATION	0.0	0.3	1.4	0.0	1.4	0.0	0.5	0.4
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SOURCE: MINISTRY OF HEALTH DATA DEVELOPMENT BRANCH

Addictions Services

There are a number of addictions services available in the Manitoulin/Sudbury service area:

- **Sudbury Algoma Hospital Detox Centre (Sudbury)**

  This is a 19-bed detox centre operated by the Sudbury Algoma Hospital. It offers a protective setting in which intoxicated persons may stay while withdrawing from the effects of acute alcoholism. Rest, personal hygiene, a balanced diet, group therapy and daily counselling is stressed. Referrals are made to other agencies for structured treatment programs.

- **Men's Social Services Salvation Army Alcohol Treatment Clinic (Sudbury)**

  The Men's Social Service Centre offers a 28-day intensive residential treatment program. A 10-bed hostel is also available for continued follow-up. The program uses an Alcoholics Anonymous approach and spiritual motivation.

- **N'Swaknok Native Friendship Centre Alcohol and Drug Abuse Program (Sudbury)**

  The native friendship centre in Sudbury offers alcohol and drug abuse counselling and provides general mental health assessments of native individuals and referrals as appropriate to active treatment programs. The centre also provides case management and follow-up services.

- **Alcoholism and Drug Research Foundation (Sudbury)**

  This organization plays a major role in areas of planning, promotion, prevention, early case identification, assessments, referrals and counselling. Representatives played an important role in the Task Force which prepared the proposal for Sudbury Algoma Comprehensive Addictions Services.

Other important players in addictions services include the St. Leonard's halfway house, the N.N.A.D.A.P. Program and the Rainbow Lodge residential treatment program in Wikwemikong which are funded by the Federal Government to provide services for native people. Some of the other groups involved in addictions services are the Northern Region Recovery Home for Women, operated by volunteers in Sudbury, Rockhaven for recovering alcoholics, the Alcohol and Drug Concerns Inc. and Robins Hill Women's Home.

Children's Services

The major children's services in the Manitoulin/Sudbury area include:

- **the Children's Mental Health Centre (Sudbury);**
- **Francophone Psycho-Social Assessment Service (at Sudbury Algoma Hospital);**
- **Children's Aid Society; and,**
- **Children's Services Co-ordinating and Advisory Group.**

* * * * *

As reported in the mental health questionnaire, many other groups/agencies have roles in mental health such as Boards of Education, MCSS-funded programs such as family life centres, homes for the aged/nursing homes, Genevra House, homes for special care, the United Chiefs and Council and other native groups, churches, police, public health units. The list of other interested groups is lengthy and includes many volunteer/self-help agencies (Recovery Inc., Survivor Group, Telecare, Ontario Friends of Schizophrenics, Big Sisters and Big Brothers).

Planning Bodies

There are many groups in the Manitoulin/Sudbury service area which report that they have a role in the planning and co-ordination of mental health services, in fact a total of 43 organizations responded to the questionnaire that they participate in planning.

Some of the leaders in planning are the Manitoulin/Sudbury District Health Council and its mental health sub-committee, and the Ministry of Community and Social Services (MCSS) which provides a range of related programs. Sudbury Algoma Hospital and the Sudbury Health Unit have been very involved in the planning and development of services. As mentioned before, the Addictions Research Foundation has been a key player in the development of the Addictions Services program proposal.

For children's services, the Children's Services Co-ordinating and Advisory Group takes leadership in planning along with the MCSS which funds children's services.

Strengths and Weaknesses

Manitoulin/Sudbury had a response rate of 30% of general practitioners and 36% of hospitals, community-based agencies and other groups which were sent questionnaires or were interviewed. In Manitoulin/Sudbury, only 6 GPs or 17% of respondents reported that they provide a mental health service. Some of the services provided include treatment, detoxification support and counselling.

In answer to the question on strengths in current mental health services, the first ranked response was "none" as reported by almost 17% of respondents. An 11% (4 respondents) reported strengths as psychiatrists, counselling services, accessibility and good communications. In Manitoulin/Sudbury, one out of three providers and agencies who responded to the questionnaire thought that good communications was a strength; this answer was followed-up by Sudbury Algoma Hospital which was considered by 25% to be a strength. Other strengths in the area are dedicated, qualified staff, the mental health clinics, accessibility, the Sudbury General programs and public education. This was the only area where "education" was noted as a strength.

There were, however, numerous weaknesses in services and their availability. While listed as a "strength" by 30% of respondents, 24% of providers and agencies thought that communications and co-ordination of services were weaknesses. It is interesting to note that this answer ranked first as both the greatest strength and greatest weakness in services. A lack of professional personnel was perceived by 24% of respondents as a weakness. Other weaknesses were lack of funding, lack of "support" services, lack of education, lack of addictions treatment, lack of psychiatrists and housing.

One out of four respondents identified lack of psychiatrists or lack of mental health professionals as a major weakness; 18% considered children's services to be lacking, followed by 16% who reported that unclear roles and lack of communication were deficient.

Application of the Model

As shown in the following Exhibit 27, the Manitoulin/Sudbury population base which is used is 200,800 for a model which should be fully implemented by year 2001. The chronic population/major users of mental health services is estimated to be 1,250 based on 6.25 chronic users per 1,000 general population.

The regional psychiatry services are shown in the model for Manitoulin/Sudbury as residents will have access to these

EXHIBIT 27

MANITOULIN/SUDBURY MENTAL HEALTH SERVICES MODEL IN YEAR 2001
GENERAL POPULATION BASE: 200,800
CHRONIC PSYCHIATRIC POPULATION: 1,250

REGIONAL PSYCHIATRIC SERVICES	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
1. ADULT SECURE UNIT	REGIONAL SERVICE - 26 BEDS	24 BEDS WITH STAFF AT N.B.P.H.	
2. SPECIALIZED ADULT DEVELOPMENTALLY HANDICAPPED UNIT	REGIONAL SERVICE - 26 BEDS	NOTHING FORMALIZED IN NORTHEAST OR NORTHWEST ONTARIO, HOWEVER THERE ARE 18 PATIENTS IN N.B.P.H. SPECIAL REHABILITATION BEDS WHO MAY QUALIFY	26 BED DEVELOPMENTALLY HANDICAPPED UNIT WITH 27-30 STAFF; POSSIBLE MIX 60-70% PROFESSIONAL RN'S
3. ADULT CONTINUING CARE UNIT	REGIONAL SERVICE - 60 BEDS	SPECIAL REHABILITATION UNITS WITH 154 BEDS AND STAFF AT N.B.P.H.	
4. CHILDREN'S IN-PATIENT UNIT	REGIONAL SERVICE - 10 BEDS	32 BEDS AT SUDBURY ALGOMA SERVING NORTHEAST/NORTHWEST ONTARIO, PARRY SOUND, MUSKOKA AND BEYOND	REFOCUS OF THE 10 CHILDREN'S BEDS ON NORTHEAST ONTARIO ONLY
ESSENTIAL COMPONENTS OF THE MENTAL HEALTH SYSTEM IN THE SERVICE AREA			
5. ADULT COMMUNITY-BASED SERVICES			
- CASE MANAGEMENT SERVICES	42-50 CASE MANAGERS	THROUGH THE SUDBURY ALGOMA COMMUNITY CLINICS PROGRAM, MENTAL HEALTH WORKERS PROVIDE THIS FUNCTION AS PART OF THEIR ROLES, ESTIMATE THIS TO BE 40% OF THE FUNCTION OR 12 STAFF SUDBURY DISTRICT HEALTH UNIT - MENTAL HEALTH LIAISON PROGRAM ALL PUBLIC HEALTH NURSES SPEND SOME TIME IN CASE MANAGEMENT SOCIAL WORK DEPARTMENTS IN GENERAL HOSPITALS	30-38 ADDITIONAL CASE MANAGERS
- SUPPORTIVE INDEPENDENT LIVING (S.I.L.) PROGRAM	18 S.I.L. WORKERS	NOTHING	18 S.I.L. WORKERS

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- HIGH/MEDIUM SUPPORT HOUSING	24 BEDS WITH 27-33 TOTAL STAFF	NOTHING	24 BEDS (IN 3 HOMES) WITH 27-33 TOTAL STAFF
- DROP-IN CENTRES	2-4 CENTRES WITH 4-8 TOTAL STAFF	SUDBURY COMMUNITY DROP-IN CENTRE IN LIVELY - STARTING SUMMER, 1986 SALVATION ARMY SOCIAL SERVICE CENTRE	NEW PROGRAMS WITH 4-8 STAFF - EACH WITH 1-2 PAID STAFF AND EXTENSIVE VOLUNTEER INVOLVEMENT.
- EMPLOYMENT PROGRAMS			
. SUPERVISED WORK SITES	1-2 WORK SITES WITH 3-6 TOTAL STAFF	VERY LITTLE EXISTS FOR THE INDIVIDUAL WITH LIMITED VOCATIONAL POTENTIAL	1-2 WORK SITES WITH 3-6 TOTAL STAFF
. JOB DEVELOPMENT PROGRAM	2-3 JOB SUPERVISORS	NOTHING	2-3 JOB SUPERVISORS
. EMPLOYMENT COUNSELLING AND ASSISTANCE PROGRAMS	ACCESS TO PROGRAMS FOR HIGH POTENTIAL PEOPLE	VOCATIONAL REHABILITATION SERVICE - SUDBURY CANADA EMPLOYMENT CENTRES BOARDS OF EDUCATION COMMUNITY COLLEGE PROGRAMS LAURENTIAN UNIVERSITY SOCIAL SERVICES DEPARTMENTS NATIVE FRIENDSHIP CENTRES	
- COMMUNITY MENTAL HEALTH CENTRES	BROAD RANGE OF COUNSELLING, EDUCATION, PREVENTION AND SELF-HELP PROGRAMS AS APPROPRIATE TO MEET LOCAL NEEDS.	FUNCTIONS PERFORMED BY A BROAD RANGE OF GROUPS: SUDBURY ALGOMA - CENTRAL AND LOCAL COMMUNITY CLINICS - ESTIMATE 60% OF STAFF OR 18 TOTAL EXPANDED PSYCHIATRIC DAY CARE PROGRAM - 6-7 STAFF GP'S YMCA/YWCA PROGRAMS	THIS COMPONENT IS DIFFICULT TO QUANTIFY IN THE SENSE OF NEED WHICH APPEARS UNLIMITED - PRIORITIES MUST BE DETERMINED BY THE SERVICE AREA.

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- COMMUNITY MENTAL HEALTH CENTRES (CONT'D)		NATIVE ESKIMO/OTHER NATIVE FRIENDSHIP CENTRES	
		NADMADWIN CLINIC	
		PUBLIC HEALTH NURSES, V.O.N.	
		SERVICE FAMILIAL DE LA REGION DE SUDBURY - 10-12 STAFF	
		PROFESSIONALS IN PRIVATE PRACTICE	
		THE NEW SUDBURY COMMUNITY SERVICE CENTRE	
		RECOVERY INCORPORATED	
		SURVIVOR GROUP	
		ONTARIO FRIENDS OF SCHIZOPHRENICS	
		WIKWIMIKONG COMMUNITY HEALTH CENTRE	
		TELECARE	
		BIG SISTERS/BIG BROTHERS	
		JOHN HOWARD SOCIETY	
		CENTRE DES JUENES DE SUDBURY	
- OTHER LOCALLY DEVELOPED SERVICES		RESIDENTIAL HOMES FOR SPECIAL CARE - 42 BEDS IN 7 HOMES	
6. ADULT HOSPITAL-BASED SERVICES			
- CRISIS INTERVENTION PROGRAMS	1-2 FORMAL PROGRAMS WITH 6-8 TOTAL STAFF PLUS SPECIAL PROGRAMS CURRENTLY FUNDED IN THE SERVICE AREA	SUDBURY GENERAL CRISIS INTERVENTION - 2-3 CRISIS WORKERS	1-2 FORMAL PROGRAMS WITH 6-8 ADDITIONA STAFF
		DEPRESSION MANAGEMENT AND SUICIDE PREVENTION - MANITOULIN MENTAL HEALTH CLINIC	
		COMMUNITY HOSPITALS	TRAINING FOR COMMUNITY HOSPITALS AND OTHER AGENCIES WITH STRONG NETWORKING AND COMMUNICATIONS
		SUDBURY ALGOMA CLINICS	

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- CRISIS INTERVENTION PROGRAMS (CONT'D)		OTHER PROGRAMS WITH A ROLE: TELECARE CHILDREN'S MENTAL HEALTH SERVICES C.A.S. ASSOCIATIONS FOR THE MENTALLY RETARDED PUBLIC HEALTH NURSES, V.O.N. FAMILY LIFE CENTRES INDIAN FRIENDSHIP CENTRES FAMILY RESOURCE CENTRES (HAVEN HOUSE, NATIVE CHILD & FAMILY RESOURCE) GENEVRA HOUSE OPP GPS HOMES FOR THE AGED, NURSING HOMES HOMES FOR SPECIAL CARE SOCIAL SERVICES DEPARTMENTS	
- "ACUTE" PSYCHIATRY BEDS	80 BEDS WITH 82-86 TOTAL STAFF	65 BEDS AT SUDBURY ALGOMA WITH 107 STAFF 36 BEDS AT SUDBURY GENERAL WITH 44.7 STAFF	
- GERIATRIC OUTREACH PROGRAM	6-8 STAFF	NOTHING FORMALIZED	6-8 STAFF
- AMBULATORY CARE SERVICES	FORMAL SERVICE TO SUPPORT THE IN-PATIENT FUNCTION WITH 15-20 TOTAL STAFF	SUDBURY ALGOMA OUT-PATIENT SERVICE CLINIC SUDBURY GENERAL DAY TREATMENT PROGRAM - 4-5 STAFF	A COMPREHENSIVE SERVICE WITH A RANGE OF TREATMENT PROGRAMS WITH 11-15 TOTAL STAFF
- HOSTEL SERVICE	A HOSTEL WITH 2-4 TOTAL STAFF	NOTHING	A HOSTEL WITH 2-4 TOTAL STAFF

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
7. CHILDREN'S ACUTE PSYCHIATRY BEDS	20 ACUTE CARE BEDS WITH 26-32 TOTAL STAFF	SHARE OF REGIONAL SERVICE	20 BEDS WITH 7 STAFF ON DAY/EVE; 2 RN, 4 CHILD CARE, 1 RECREATION THERAPIST; RN AND 2 CHILD CARE WORKERS AT NIGHT (26-32 TOTAL STAFF)
8. CHILDREN'S MENTAL HEALTH CENTRE	1 PROGRAM WITH BRANCH OFFICES AS APPROPRIATE	CHILDREN'S MENTAL HEALTH CENTRE IN SUDBURY - 16 STAFF	ESTABLISH PUBLIC HEALTH NURSES WITHIN THE SCHOOL SYSTEM - 10-15 SCHOOL-BASED MENTAL HEALTH NURSES
		FRANCOPHONE PSYCHO-SOCIAL ASSESSMENT SERVICE - 10 STAFF	CONSOLIDATION OF CURRENT SERVICES WHILE PRESERVING A HIGH LEVEL OF COMMITMENT T THE FRANCOPHONE COMMUNITY
9. PSYCHIATRISTS	20 PSYCHIATRISTS	6 PSYCHIATRISTS AT SUDBURY GENERAL 10 PSYCHIATRISTS AT SUDBURY/ALGOMA EXPECTING 3 MORE PSYCHIATRISTS BY SEPTEMBER	1 PSYCHIATRIST
10. ADDICTIONS SERVICES PROGRAM COMPONENTS INCLUDE: - HEAD OFFICE - ASSESSMENT, REFERRAL, CASE MANAGEMENT - DAY TREATMENT PROGRAM - OUT-PATIENT PROGRAM - AFTER-CARE PROGRAM	ONE COMPREHENSIVE PROGRAM PER SERVICE AREA TO COMPLEMENT AND ENHANCE EXISTING SERVICES	NOTHING EXISTS IN THIS FORM CURRENTLY	SUDBURY ALGOMA PILOT - 36-40 STAFF REQUIRED PLUS SPACE, EQUIPMENT
- DETOX BEDS		SUDBURY ALGOMA DETOX - 19 BEDS WITH 10 STAFF	
- SUPERVISED RESIDENCE - COMMUNITY ADDICTIONS SERVICES WORKERS			

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
10. ADDICTIONS SERVICES (CONT'D) EXISTING SERVICES		ADDICTION RESEARCH FOUNDATION - 4 STAFF	LINKAGES WITH THE COMPREHENSIVE PROGRA AS APPROPRIATE
		ST. LEONARD'S HALFWAY HOUSE	
		N'SWAKNOK NATIVE FRIENDSHIP CENTRE - CASE MANAGER & REFER. ALCOHOL AND DRUG ABUSE PROGRAM, 0.5 STAFF	
		MEN'S SOCIAL SERVICES SALVATION ARMY ALCOHOLIC TREATMENT CLINIC 28-DAY/10 BED LIVE-IN PROGRAM FOR MEN - 3 STAFF	
		N.N.A.D.A.P. PROGRAM - ALCOHOL WORKERS ON THE RESERVE - COUNSEL (FEDERAL) WIKWIMIKONG	
		FRATERNITY HOSTEL - COMSOC	
		RAINBOW LODGE ALCOHOL TREATMENT CENTRE - 7 BEDS - WIKWIMIKONG (FEDERAL)	
		ROCKHAVEN - 18 BEDS (FOOD AND SHELTER) RECOVERING ALCOHOLICS - 4 STAFF	
		COMSOC - SOME GROUPS, LONG-TERM RESIDENTIAL	
		NORTHERN REGION RECOVERY HOME FOR WOMEN - STAFFED BY RECOVERING ALCOHOLICS - 16 BEDS - PAID STAFF (SUDBURY), 4 STAFF	
		ALCOHOL AND DRUG CONCERNS INC.	
		ROBINS HILL WOMEN'S HOME, INC., 2 STAFF	

highly specialized services where appropriate. Otherwise, the services which are identified within the services area should be sufficient generally to meet the needs of the population.

Case Management

Currently a range of groups perform the case management function. It is a fragmented responsibility assumed by key players such as public health nurses and a range of funded community mental health clinics, and social workers at hospitals. The full-time case managers proposed under this model will supplement current functions with 30 to 38 new positions required. Such case managers should be distributed across Manitoulin/Sudbury, considering the concentrations of francophones and natives in the area.

While the majority (70%-75%) will likely be required in the Regional Municipality of Sudbury, case mangers should be considered for Walden, Onaping Falls, Espanola and Manitoulin Island. It is specifically recommended that francophone and native individuals be recruited as case managers. to ensure that at least 15 are fluently bilingual or francophone and will be available in communities such as Valley East; and that 7 or 8 native individuals serve as case managers to provide necessary linkages to the 11 reserves, and to address specific needs of native people living in the cities.

Supportive Independent Living Program (SIL)

There is nothing similar to this program currently. As one of its services, the psychiatric day care program at Sudbury General Hospital does provide some life skills training to clients as required. Eighteen SIL workers are required in Manitoulin/Sudbury, of which 5 or 6 should be francophone or fully bilingual and at least 1 or 2 should be native individuals.

High/Medium Support Housing

There are no existing housing programs in Manitoulin/Sudbury comparable to those proposed under this model. Thus, homes with 24 beds and 24-hour staffing are recommended. These homes may be all in the city of Sudbury, or the CMHMB may consider such locations as Manitoulin Island or Valley East to provide programs tailored to the needs of the chronic psychiatric francophone/native groups. High support services generally require back-up from acute care services and communication between local GPs and psychiatry services in Sudbury would be necessary.

Drop-In Centres

A new drop-in centre in Lively is being developed by the local branch of the Canadian Mental Health Association. It will receive funding as a community mental health program. This will be the first drop-in centre in Sudbury. Under this model, there are options to be very creative, to build upon this new program (including work opportunities, etc.) or to introduce additional drop-in centres where there is a sufficient number of psychiatrically disabled individuals to warrant a service. A total of 2 to 4 centres is recommended under this model.

While it is not a formally funded as a drop-in centre, the Salvation Army Social Centre in Sudbury also provides social/recreational opportunities for some individuals with mental health problems.

Employment Programs

Manitoulin/Sudbury requires a range of "employment" programs for individuals with mental health problems. There is a need for 2 work sites which might take the form of a sheltered workshop or be creatively developed as a program of the drop-in centre (similar to the Progress Place model). A work site will likely be required in Sudbury as a priority. Such a program might be developed in conjunction with the Vocational Rehabilitation Services in Sudbury which has historically been available to very high potential candidates.

As well, a job development program is required with 2 to 3 staff. To this end, relationships should be developed between job supervisors, mental health workers (case managers) and existing organizations such as Canada Employment Centres, Boards of Education, Community College Programs, the March of Dimes program and the Social Services Department. As well, native case managers should work directly with the Native Friendship Centres and Band representatives to develop additional programs for native residents with identified mental health problems.

Community Mental Health Centres

Current staff who perform functions of counselling, education, prevention and self-help programs are preserved under the model. The major groups involved in services are the Sudbury Algoma Hospital Clinics, the Sudbury General Hospital Day Care Program, native friendships centres, Service Familial de la region de Sudbury, some professionals in private practice and a range of self-help/volunteer agencies.

The CMHMB will need to consider these programs in the context of the specific target group served and in light of expected outcomes and results.

As suggested for children's mental health centres, clearly defined plans are required to ensure that resources are utilized in a cost-effective manner. Demand for such services could be infinite and it will be the responsibility of the CMHMB to work with the Manitoulin/Sudbury DHC to priorize requests for new programs which they would suggest the Ministry of Health fund in light of what other groups and volunteer agencies are doing.

As noted, there is a whole range of programs, including MCSS-funded and programs volunteer agencies which are involved in community mental health programs.

Residential Homes for Special Care

Residential homes for special care provide room and board for psychiatrically disabled individuals as funded by the Ministry of Health. Homes should be considered as part of the range of housing options for individuals with a chronic mental disability in the community. Case managers will work with home operators, as they will with private apartment superintendents and boarding home operators to provide support and assistance and to maintain the client at his/her optimal level of function. SIL workers will provide support services to clients in residential homes for special care if this is an aspect of the individual's treatment plan. There are 7 residential homes with 42 beds in Manitoulin/Sudbury.

Crisis Intervention Programs

The Sudbury General Hospital has a small crisis intervention program which could easily be expanded under this model. As well, there is a depression management and suicide prevention program at the Manitoulin Mental Health Clinic and the crisis services provided by workers at the Sudbury Algoma Hospital clinics as required. Such programs/existing strengths should be preserved and considered by the CMHMB in decisions to institute additional services.

As well, other programs consider crisis intervention to be a major role such as Haven House, the Ontario Fiends of Schizophrenics, some churches and native friendship centres, children's aid and community hospitals.

It is recommended that the formal program staff in the system, with their expertise, take a leadership role in educating other hospital staff and mental health personnel throughout the service area to deal with mental health and other crises and especially with workers in small communities to develop policies and procedures for dealing with a crisis. As discussed, many of the groups listed in Exhibit 27 could benefit from working relationships with the formal crisis intervention programs.

Acute Psychiatry Beds

There are currently 101 acute adult psychiatry beds in Sudbury; 65 at Sudbury Algoma Hospital and 36 at the Sudbury General Hospital. This model recommends 80 total adult acute psychiatry beds. This recommendation incorporates the idea that psychiatry should be part of the general hospital system and the mainstream of medical services. As significant planning and restructuring of adult services is therefore required in Sudbury, specific recommendations on the size and nature of adult in-patient services are presented in Exhibit 28. One will also note that Sudbury will retain the 30 beds for the regional children's service and for the Manitoulin/Sudbury children's service.

The reader will note that the 80-bed adult service is designed to meet the acute care needs of various age groups and also considers the needs of adolescents 16 to 19 years of age who may use the "youth" service. This type of allocation should be seriously considered in the redevelopment of this service and the extensive ambulatory treatment programs which will complement these functions.

Ambulatory Care Services

Such services are recommended to provide active treatment programs to support the 80-bed acute psychiatry in-patient unit. It will be available to patients who travel in to receive services and stay at the hostel. It should also be available to individuals who live at home and commute.

The Sudbury Algoma Out-Patient Service and the Sudbury General Hospital Day Treatment Program currently play a role in providing ambulatory care, however the service which is recommended is significantly larger in numbers of staff, broader in its role and is "active" treatment oriented.

Hostel

At least one hostel is required to accommodate patients involved in ambulatory care who may travel a distance for care, yet not require hospitalization.

EXHIBIT 28

SUDBURY: 80 BED ADULT ACUTE PSYCHIATRY SERVICE

	BEDS	SERVICE (ALL ALOS 3 WEEKS)
	20	YOUTH (16-25 YEARS OF AGE)
	20	GENERAL ADULT PSYCHIATRY (26-64 YEARS OF AGE)
	20	HIGH RISK (ANY AGE)
	20	ELDERLY ADULT (AGE 65 AND OVER) INCLUDES A MEDICAL LIAISON SERVICE
	80	
PLUS	10	"REGIONAL" CHILDREN'S BEDS
	20	CHILDREN'S BEDS FOR MANITOULIN/ SUDBURY
SUB TOTAL PSYCHIATRY	110	

Geriatric Outreach

This program requires 4 to 5 professional staff assisted by a psychiatrist. The program will likely be based out of the general hospital which operates the designated 80-bed psychiatric service and full range of ambulatory, crisis and hostel services.

Outreach should be provided and staff will likely travel throughout the service area and to some of the smaller communities to provide services.

Another option is to place some of the geriatric program staff in selected communities. This will likely be decided jointly by the CMHMB and leading hospital provider.

Children's Acute Psychiatry Beds

As discussed previously, the current 32 regional children's acute care beds will be redefined to include a 10-bed regional service for Northeast Ontario and 20 beds for the Manitoulin/ Sudbury service area. All beds are recommended to be transferred to the Ministry of Health, and as suggested for the 80-bed service, children's psychiatry should become part of a general hospital service.

As discussed previously, clarification of the role and scope of the regional services along with new services in each service area, is expected to result in a major improvement in service accessibility.

Children's Mental Health Centre

Unique to the Manitoulin/Sudbury service area is the fact that there are two children's mental health centres in Sudbury, one generic children's mental health centre and one for francophones. Enhancements to the services of children's mental health centres in all service areas are suggested with the introduction of public health nurses working in mental health within the school system.

Psychiatrists

Based on a standard of 1 psychiatrist per 10,000 general population the Manitoulin/Sudbury area currently has 16 psychiatrists, which is 4 short of the 20 based on this formula. It is interesting to note that lack of psychiatrists was noted by GPs as a weakness in the current services. It should be noted, however, that the model proposed is not dependent upon psychiatrists and recommends that GPs be trained and developed to deal with the supportive, on-going maintenance needs of chronic psychiatrically disabled individuals in their communities.

Addiction Services

As discussed under Section VI, Introduction to the Model, it is recommended that the Sudbury Algoma Hospital Task Force proposal for a comprehensive addictions service be funded as a pilot program. It is further recommended that the experience/insight gained through this pilot be used to assist other service areas to develop similar programs throughout the Northeast.

Implementation Considerations

Providers and agencies in Manitoulin/Sudbury suggested that the following major obstacles need to be addressed in implementing a comprehensive mental health services model. The major obstacles are ranked in order of respondent frequency as follows:

- 54% said lack of funding;
- 26% said lack of personnel;
- 25% said lack of communication; and
- 14% reported interagency competition and rivalries.

Some of the major implementation activities which must take place in Manitoulin/Sudbury are:

- establishment of a CMHMB; and integration of current mental health services under the CMHMB while preserving existing strengths.

- strengthening of communication and co-operation between agencies and providers;

- working relationships which must be established with native groups and federal and band representatives, especially on Manitoulin Island, to address jointly the special mental health needs of natives;

- education and promotion of the model to prepare the public for the model and its new service components;

- overall redefinition of treatment and accommodation functions by providers to match the requirements of the model;

- reduction in beds currently in the system and redevelopment of an 80-bed acute psychiatry service as part of a general hospital;

- development of comprehensive ambulatory care programs and a hostel with enhancements to crisis programs;
- establishment of the full range of community-based programs, including a range of housing types for the psychiatrically disabled individual;
- recruitment, retention and deployment of an appropriate number of french speaking and native workers, overall, by 2001 it is estimated that 110 to 126 workers should be fully bilingual and 25 to 30 native workers;
- specific recruitment of additional mental health workers and specifically case managers and SIL workers who have francophone/native backgrounds who must be redeployed in areas with the greatest need; and
- redefinition of the current children's regional psychiatry service;

Leadership within the Community Health Management Board will be especially important to successful implementation of the total model. In model testing sessions, one common concern was that existing providers have a significant role and that strengths be preserved. A letter was received by the Steering Committee in follow-up to the testing sessions from the Manitoulin/Sudbury District Health Council (Mental Health Committee) expressing interest that:

> "the organizational structure proposed for community mental health programs...be able to adequately address the weaknesses in the system, yet be flexible and sensitive enough to reinforce the strengths in the system in the Manitoulin/Sudbury Districts. The community mental health system in this area is characterized by several players who have been recognized as providing high quality service, including the Sudbury Algoma Hospital (both out-patient and community clinics programs), as well as the local branch of the Canadian Mental Health Association. The proposed Community Mental Health Management Board, if it is to be introduced, must recognize and support the contributions that these organizations have made towards the provision of services and maintain at least the present level and quality of services. It was suggested that instead of introducing a totally new structure, it might be preferable to amend one of the existing structures in the area to provide for the co-ordination of community mental health services".

The letter further suggested that "one possibility might be the development of a community programs board under the Sudbury Algoma Hospital, for example with appropriate community agency input." and stressed that "in any case, the present organizational dynamics of this area must be recognized in any modifications."

Furthermore, representatives of the Sudbury Algoma Hospital have expressed strong interest in a leadership role, possibly assuming the function of the proposed CMHMB.

The Steering Committee supports that key groups such as Sudbury Algoma Hospital will be important to include in the CMHMB membership and may naturally assume a leadership role. However, information collected during this study pointed to many current weaknesses in the Manitoulin/Sudbury service area including the lack of communication and inter-agency competition and rivalries which were noted as two of the four major obstacles to implementing a comprehensive model. To this end, it is recommended that the CMHMB be a new Board where such obstacles can be overcome.

* * * * *

As shown in Exhibit 21, Summary of Positions in Mental Health, Manitoulin/Sudbury currently has 257 to 262 mental health positions, excluding the 127 at Sudbury Algoma Hospital for the Regional Children's Service. The service area requires a total of 365 to 421 in order to implement the proposed model. To this end, staffing of mental health services in Manitoulin/Sudbury will almost double, costing $12.8 to $15 million a year for staffing.

THE NIPISSING/TIMISKAMING SERVICE AREA

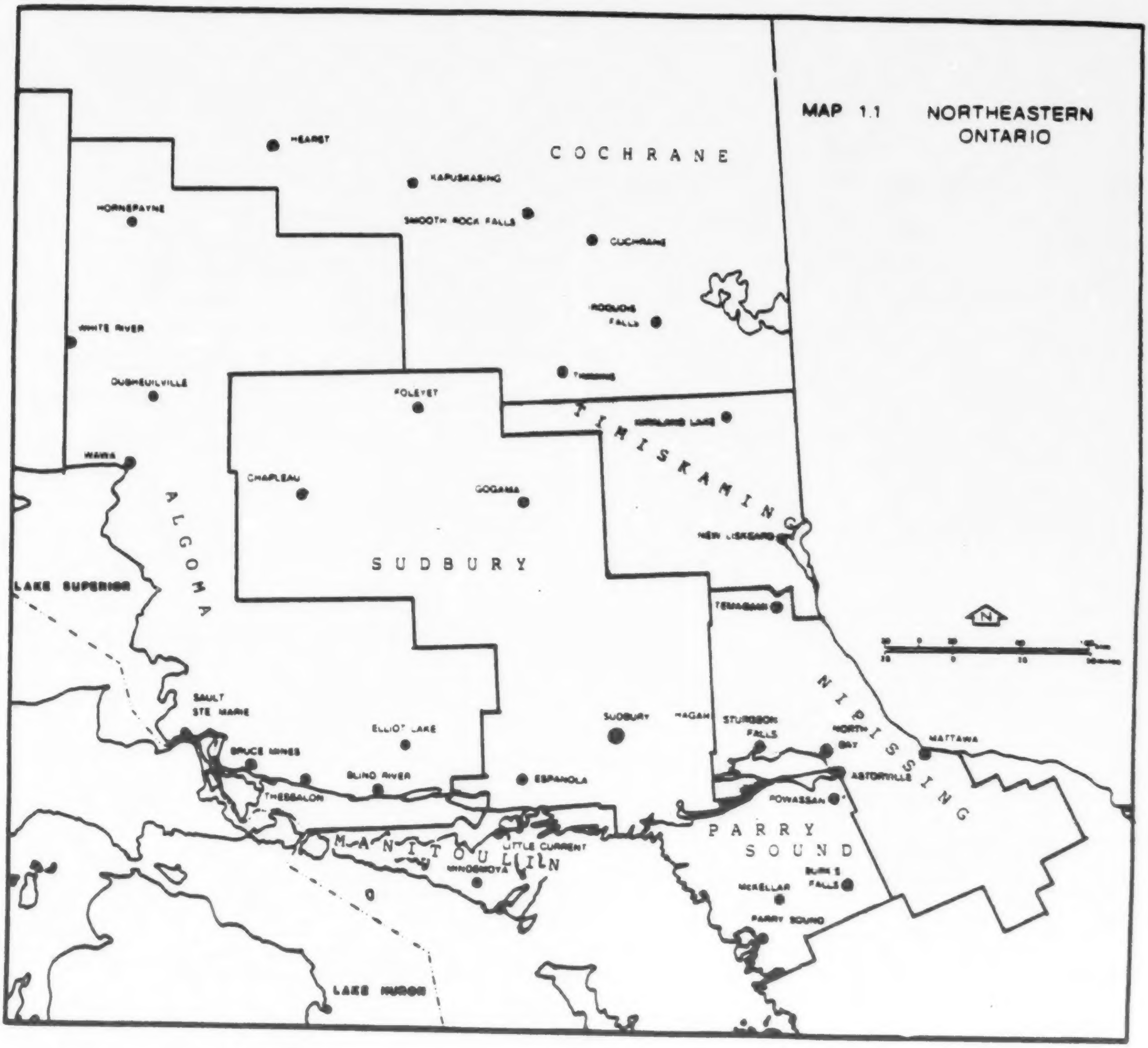
As shown in Exhibit 29, the Nipissing/Timiskaming Service Area is the smallest of the four defined service areas, representing 30,717 square kilometers. It borders Quebec to the east, Cochrane to the north, and the Sudbury service area to the west. Parry Sound borders to the south and some of its residents have traditionally relied on services provided in North Bay by the NBPH.

In 1981, Nipissing/Timiskaming had a combined population of 121,556 with approximately 40,000 or one-third of residents in Timiskaming and 80,000 or two-thirds in Nipissing. The combined population results in a population density of 4.0 residents per square kilometer.

The number of Nipissing/Timiskaming residents is projected to remain virtually constant to year 2001 with a projected

EXHIBIT 29

NORTHEASTERN ONTARIO: NIPISSING/TIMISKAMING SERVICE AREA


MAP 1.1
NORTHEASTERN ONTARIO
COCHRANE
HEARST
KAPUSKASING
SMOOTH ROCK FALLS
COCHRANE
HORNEPAYNE
IROQUOIS FALLS
WHITE RIVER
TIMMINS
DUBREUILVILLE
FOLEYET
TIMISKAMING
KIRKLAND LAKE
WAWA
CHAPLEAU
GOGAMA
ALGOMA
NEW LISKEARD
SUDBURY
LAKE SUPERIOR
TEMAGAMI
N
NIPISSING
SAULT STE MARIE
ELLIOT LAKE
SUDBURY
HAGAR
STURGEON FALLS
NORTH BAY
MATTAWA
BRUCE MINES
BLIND RIVER
ESPANOLA
ASTORVILLE
THESSALON
POWASSAN
PARRY SOUND
MANITOULIN
LITTLE CURRENT
MINDEMOYA
BURK'S FALLS
McKELLAR
PARRY SOUND
LAKE HURON

121,178 residents. The major population centres in the service area are:

- North Bay with a population of 51,268 or 42.3% of Nipissing/Timiskaming residents;
- New Liskeard/Tri-Town area including Haileybury, Cobalt, and New Liskeard with 13,924 or 11.5% of residents;
- Kirkland Lake with 12,219 or 10.1% of residents; and
- Sturgeon Falls with 6,045 or 5% of residents.

As shown above, almost 70% of residents in the service area reside in one of these four urban areas.

Nipissing/Timiskaming is primarily anglophone with 67% of residents reporting english as their mother tongue. Twenty-eight percent, however are francophone and another 5% report "other" mother tongue. Concentrations of francophones may be found in Sturgeon Falls, in the Astorville/Mattawa areas and scattered throughout Timiskaming, especially near the Quebec border. Nipissing/Timiskaming has 3 small native reserves with 871 residents.

As reflected in 1981 census data, this service area falls behind the other three service areas in labour force participation with only 73.%% of men and 45.4% of women participating. The area also reported the lowest income levels for both men and women who earned $14,969 and $6,914 respectively, compared to the average for Northeast Ontario of $16,742 for men and $7,120 for women.

Educational levels show Nipissing/Timiskaming at the average for the Northeast with 22.3% of individuals having less than Grade 9 schooling.

Major Mental Health Providers

Hospital Providers

As discussed in the utilization review, the major designated hospital provider is the North Bay Psychiatric Hospital, which has 26 designated acute admissions beds for Nipissing/Parry Sound/Timiskaming. All other beds are regional. There are no designated psychiatry beds in the Timiskaming part of the service area, however utilization data shows community hospitals in the area to be very active in the provision of care. On an average day, the hospitals in New Liskeard and Kirkland Lake might have 12 patients in general beds with a psychiatric diagnosis. In Nipissing, on an average day another 8 to 9 patients are treated with a psychiatric diagnosis at either the North Bay Civic or St. Joseph's General Hospitals. In Sturgeon Falls, 2 to 3 patients on average are in the West Nipissing General Hospital with such a diagnosis.

As shown previously, the acute admissions services of NBPH exhibited the lowest occupancy level (63%) of all services during the one-day snapshot.

Separation data on Nipissing shows this part of the service area to be very self-sufficient, treating 91.6% of separations of its residents in 1984/85. Even without designated beds, Timiskaming is also relatively self-sufficient, handling almost 78% of its residents who were hospitalized with a psychiatric diagnosis, with 15% separated from NBPH.

As shown in Exhibit 30, NBPH handles the highest overall percentage of schizophrenics (36.4%), however the Kirkland and District Hospital reported that almost 35% of its separations were of individuals with affective psychoses. The reader will remember this as one of the group of "major users" under this model. Neurotic disorders are treated in all hospitals, 60.4% of Mattawa General Hospital separations were for this diagnosis. Alcoholism represents 13% of all separations in the area as shown in Exhibit 29 which also includes several Parry Sound Hospitals. A very small percentage of children are reflected in the Nipissing/Timiskaming data; 0.2% of all separations were for emotional disturbance of childhood or adolescence and an even smaller percentage was shown for hyperkinetic syndrome or delay in development categories.

Funded Community Mental Health Programs

There are a number of formally funded programs which provide services in Nipissing/Timiskaming.

- **Timiskaming Health Unit Mental Health Program**

  This is a funded community-based mental health program offering counselling and consultation to people in Timiskaming. The service is designed with two mental health teams (nurse/social worker combination) based in key urban centres (Kirkland Lake, New Liskeard). Work of the team is augmented by the public health nurses in the general program, each of whom carry a small mental health caseload. A part-time consulting psychiatrist and psychologist offer support and training to front line staff. Close contact is maintained with NBPH which is especially important to co-ordinated care and case management for discharged patients.

EXHIBIT 30

NIPISSING/TIMISKAMING
1984/85 SEPARATIONS AS % OF HOSPITAL TOTAL

		NORTH BAY CIVIC	NORTH BAY ST. JOSEPH'S	KIRKLAND & DISTRICT	NEW LISKEARD	WEST NIPISSING	PARRY SOUND DISTRICT	MATTAWA GENERAL	BURK'S FALLS	NORTH BAY PSYCHIATRIC	ENGLEHART & DISTRICT	TOTAL NIPISSING/ TIMISKAMING
290	SENILE & PRE-SENILE	4.3	0.9	6.4	2.3	0.0	3.8	0.0	4.3	2.5	0.0	2.7
291	ALCOHOL PSYCHOSIS	3.1	1.8	2.3	3.0	1.1	1.5	1.9	0.0	1.1	0.0	1.7
292	DRUG PSYCHOSIS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	1.5	0.7
293/4	OTHER ORGANIC PSYCHOSIS	0.0	0.9	0.6	0.4	0.0	0.0	0.0	0.0	1.4	0.0	0.8
295	SCHIZOPHRENIA	0.6	2.7	2.9	4.9	1.1	7.5	3.8	4.3	36.4	9.2	18.8
296	AFFECTIVE PSYCHOSIS	9.9	5.5	34.7	9.8	3.2	16.5	15.1	0.0	11.0	7.7	12.4
297	PARANOID STATE	0.0	0.0	0.0	0.8	0.0	0.0	0.0	0.0	2.0	0.0	1.0
298/9	OTHER PSYCHOSIS	2.5	2.7	5.8	4.5	8.6	1.5	1.9	0.0	1.9	7.7	3.1
300	NEUROTIC DISORDER	21.1	20.0	24.3	15.1	14.0	19.5	60.4	34.8	7.7	32.3	15.5
301	PERSONALITY DISORDER	5.0	2.7	1.7	6.0	1.1	0.8	1.9	8.7	10.8	4.6	6.9
303	ALCOHOLISM	11.8	15.5	13.3	23.4	31.2	30.8	11.3	21.7	5.6	13.8	13.2
304/5	DRUG DEPENDENCY & ABUSE	1.9	3.6	1.7	4.2	6.5	0.8	0.0	8.7	6.2	6.2	4.5
308	ACUTE REACTION TO STRESS	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0	0.3
309	ADJUSTMENT REACTION	0.6	0.0	0.6	0.0	1.1	0.8	0.0	0.0	4.7	0.0	2.4
313	EMOTIONAL DISTURBANCE CHILDHOOD & ADOLESCENCE	0.0	0.9	0.0	0.0	0.0	0.8	0.0	0.0	0.2	0.0	0.2
302/6/7/10/11/12/16	OTHER NON-PSYCH DISORDER	38.5	40.9	5.2	24.5	31.2	15.8	1.9	17.4	3.3	16.9	14.0
314	HYPERKENETIC SYNDROME	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1
315	DELAY IN DEVELOPMENT	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
317/8/9	MENTAL RETARDATION	0.0	0.0	0.6	1.1	1.1	0.0	1.9	0.0	3.3	0.0	1.8
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SOURCE: MINISTRY OF HEALTH DATA DEVELOPMENT BRANCH

- **Community Contact (Kirkland Lake)**

  This is a Canadian Mental Health Association/Kirkland Lake Branch social/recreation program targeted to psychiatrically disabled adults. It is generally open as a "drop-in" centre with self-help groups mainly for women.

- **West Nipissing Alliance Centre (Sturgeon Falls)**

  This is the recently funded community-based mental health centre in Sturgeon Falls. The Centre offers services such as assessment, diagnosis, consulting and therapy as major roles. The Centre plays a role in crisis intervention and rehabilitation as appropriate to the needs of individual clients primarily from the Sturgeon Falls area which is predominantly francophone.

- **North Bay Mental Health Services Board**

  This Board was designed to fund and operate mental health services in North Bay. To this end it funds directly two programs:

  - The North Bay Drop-In Centre which was established by the local CMHA branch and provides a range of social/recreation programs and is available to men and women over age 18 with psychiatric disabilities.

  - The NBPH Vocational Rehabilitation Workshop which is staffed by NBPH and provides the ex-psychiatric patient with work skills assessment, work adjustment training, job counselling, liaison and placement.

Addictions Services

There are several addictions services available in the area:

- **The St. Joseph's General Hospital Treatment Program (North Bay)**

  This is a newly funded community mental health program which provides residential treatment programs. Capacity includes 15 beds. This is a 28-day alcohol and drug treatment program for men and women. Expansion of the program to include more beds and out-patient programs has recently been approved.

- **Harmony House (Kirkland Lake)**

  This is an 8-bed recovery home for male alcoholics which offers some individual and group counselling, life skills training, and recreation.

- **Timiskaming Alcohol Assessment Program**

  This is a Timiskaming Public Health Unit program funded to provide assessment services and appropriate referrals for residents of Timiskaming with alcohol problems.

- **Addiction Research Foundation (North Bay)**

  The Addiction Research Foundation has a major role in promotion and prevention, research and participates in the planning and co-ordination of mental health services.

- **Commanda Health Centre (Sturgeon Falls)**

  This Health Centre is generally designed to address needs of native groups and offers alcohol and drug addiction counselling programs.

Other addictions-related programs include the North Bay Half-Way House for male alcoholics and the Vitaway Farm offering youth addictions programs.

Children's Services

The major children's mental health services in the Nipissing/Timiskaming service area include:

- **Concordia Centre - North Bay (A children's mental health centre);**
- **Child and Youth Services - Timiskaming (A children's mental health centre with offices in New Liskeard and Kirkland Lake);**
- **Children's Aid (Timiskaming and Nipissing); and**
- **Boards of Education.**

* * * * *

As reported in the mental health questionnaire, many other groups/agencies have roles in mental health such volunteer groups, MCSS-funded programs, elderly services (homes for the aged and nursing homes), the Indian Friendship Centre and police, Family Resource Centres and Associations for the Mentally Retarded.

Planning Bodies

There is no District Health Council in Nipissing/Timiskaming. However, Ministry of Community and Social Services and Ministry of Correctional Services report that they have some role and responsibility to plan and co-ordinate mental health services.

North Bay Mental Health Services Board reports planning and co-ordination as its major role but is relatively limited in its current function as it only funds two small programs. In Timiskaming, the Advisory Board to the Timiskaming Public Health Unit Mental Health Program takes a leadership role in developing services in their area.

For children, the children's mental health centres and Children's Services Coordinating and Advisory Group provides leadership in planning for services.

These organizations should be considered for membership in the CMHMB.

Strengths and Weaknesses

Nipissing/Timiskaming (with some Parry Sound respondents) had a response rate to the questionnaire of 25% of GPs and 40% of other agencies and organizations which received questionnaires or were interviewed.

In response to the question on strengths in current mental health services, 18% of GPs reported that there were no strengths, 15% reported the NBPH out-patient service to be a strength. Other providers and agencies indicated dedicated/ qualified personnel and Public Health units to be some of the greatest strengths in Nipissing/Timiskaming, however only 15% and 12% reported these services as strengths. Children's services such as CAS and children's mental health centres were also considered strengths by 10% of respondents.

The NBPH was not mentioned as a strength by GPs and only 8% of other groups cited the hospital to be a strength, despite the fact that it is the only designated acute psychiatry service for the area.

There was little consensus around strengths to be preserved under the model.

There was a higher response rate to the question on weaknesses; 35% reported lack of psychiatrists to be a weakness, almost 30% reported a lack of beds/facilities. These two responses were followed by lack of professionals and unclear provider roles and lack of communication and co-ordination as the next greatest weaknesses.

Other providers and agencies cited major weaknesses in the lack of children's/adolescent services (23%), followed by lack of communication and co-ordination (18%) and lack of public education (16%).

Application of the Model

As shown in the following Exhibit 31, the Nipissing/Timiskaming population base used is 121,100 for a model which should be fully implemented by year 2001. The chronic population or major psychiatric services user group is estimated to be 758 based on 6.25 chronic mentally disabled/1,000 general population.

The regional psychiatry services are shown in the model for Nipissing/Timiskaming as residents will have access to these highly specialized services where necessary. Otherwise, the services which are identified within the service area should be sufficient generally to meet the needs of the population.

Case Management

Currently, a range of groups perform the case management function. Public Health units of Nipissing and Timiskaming have established programs. The efforts/strengths of these providers should be preserved under the new model and serve as a sound basis for further development.

Additional case managers are required to ensure that 25 to 30 case managers are in place. As almost 30% of the Nipissing/Timiskaming catchment area is francophone, at least 8 of the case managers should be fluently bi-lingual. One or two of the case managers should be a native individual, to provide necessary linkages to the reserves and address special needs of native people.

Case managers should be available in both large communities (North Bay, New Liskeard, Kirkland Lake) and also smaller areas such as Sturgeon Falls and Mattawa.

Supportive Independent Living Program (SIL)

Life skills training and community integration program are currently offered by the Social Adaptation Program at NBPH,

EXHIBIT 31

NIPISSING/TIMISKAMING MENTAL HEALTH SERVICES MODEL IN YEAR 2001
GENERAL POPULATION BASE: 121,100
CHRONIC PSYCHIATRIC POPULATION: 758

	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
REGIONAL PSYCHIATRIC SERVICES			
1. ADULT SECURE UNIT	REGIONAL SERVICE - 24 BEDS	24 BEDS WITH STAFF AT N.B.P.H.	
2. SPECIALIZED ADULT DEVELOPMENTALLY HANDICAPPED UNIT	REGIONAL SERVICE - 26 BEDS	NOTHING FORMALIZED IN NORTHEAST OR NORTHWEST ONTARIO, HOWEVER THERE ARE 18 PATIENTS IN N.B.P.H. SPECIAL REHABILITATION BEDS WHO MAY QUALIFY	26 BED DEVELOPMENTALLY HANDICAPPED UNI WITH 27-30 STAFF; POSSIBLE MIX 60-70% PROFESSIONAL RN'S
3. ADULT CONTINUING CARE UNIT	REGIONAL SERVICE - 60 BEDS	SPECIAL REHABILITATION UNITS WITH 154 BEDS AND STAFF AT N.B.P.H.	
4. CHILDREN'S IN-PATIENT UNIT	REGIONAL SERVICE - 10 BEDS	32 BEDS AT SUDBURY ALGOMA HOSPITAL SERVING NORTHEAST/NORTHWEST ONTARIO, PARRY SOUND, MUSKOKA AND BEYOND	REFOCUS OF THE 10 CHILDREN'S BEDS ON NORTHEAST ONTARIO ONLY
ESSENTIAL COMPONENTS OF THE MENTAL HEALTH SYSTEM IN THE SERVICE AREA			
5. ADULT COMMUNITY-BASED SERVICES			
- CASE MANAGEMENT SERVICES	25-30 CASE MANAGERS	A FRAGMENTED FUNCTION PERFORMED BY A RANGE OF GROUPS: TIMISKAMING HEALTH UNIT MENTAL HEALTH PROGRAM - 6 STAFF NORTH BAY & DISTRICT MENTAL HEALTH CASE MANAGEMENT PROGRAM - 2 CASE MANAGERS SOCIAL WORKERS AT N.B.P.H. OTHER PUBLIC HEALTH UNITS, V.O.N., COMMUNITY MENTAL HEALTH PROGRAMS ASSOCIATION FOR THE MENTALLY RETARDED (FOR DEVELOPMENTALLY HANDICAPPED WITH DUAL DIAGNOSIS).	17-22 CASE MANAGERS
- SUPPORTIVE INDEPENDENT LIVING (S.I.L) PROGRAM	10 S.I.L. WORKERS	THE N.B.P.H. SOCIAL ADAPTATION PROGRAM WITH STAFF	TRANSFER CONCEPTS AND STAFF TO THIS COMMUNITY-BASED PROGRAM

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- HIGH/MEDIUM SUPPORT HOUSING	15 BEDS WITH 18-22 TOTAL STAFF	NOTHING	8 BED HOME - STAFFED 24 HOURS (1 RN, AID) 9-11 ADDITIONAL STAFF 7 BED HOME - STAFFED 24 HOURS (1 RN, AID) 9-11 ADDITIONAL STAFF
- DROP-IN CENTRES	2-4 CENTRES WITH 4-8 TOTAL STAFF	NORTH BAY C.M.H.A. DROP-IN - 4 STAFF COMMUNITY CONTACT (KIRKLAND LAKE) - 1 STAFF	NEW PROGRAMS WITH UP TO 3 ADDITIONAL STAFF AS APPROPRIATE - EACH WOULD HAV 1-2 PAID STAFF AND EXTENSIVE VOLUNTEE INVOLVEMENT
- EMPLOYMENT PROGRAMS			
. SUPERVISED WORK SITES	1-2 WORK SITES WITH 3-6 TOTAL STAFF	N.B.P.H. VOCATIONAL WORKSHOP - 10.5 STAFF	POSSIBLY ONE NEW WORK SITE
. JOB DEVELOPMENT PROGRAM	2-3 JOB SUPERVISORS	A LIMITED FUNCTION OF THE WORKSHOP	2-3 JOB SUPERVISORS
. EMPLOYMENT COUNSELLING AND ASSISTANCE PROGRAMS	ACCESS TO PROGRAMS FOR HIGH POTENTIAL PEOPLE	CANADA EMPLOYMENT CENTRES BOARDS OF EDUCATION COMMUNITY COLLEGE PROGRAMS - YOUTH START (CANADORE) SOCIAL SERVICES BOARD SEVEN ARROWS LEARNING CENTRE NATIVE FRIENDSHIP/NATIVE TRAINING PROGRAMS	
- COMMUNITY MENTAL HEALTH PROGRAMS	BROAD RANGE OF COUNSELLING, EDUCATION PREVENTION AND SELF-HELP PROGRAMS AS APPROPRIATE TO MEET LOCAL NEEDS.	FUNCTIONS PERFORMED BY A BROAD RANGE OF GROUPS: WEST NIPISSING ALLIANCE CENTRE IN STURGEON FALLS - 2-3 STAFF NORTH BAY FAMILY LIFE CENTRE - 14 STAFF	THIS COMPONENT IS DIFFICULT TO QUANTIF IN THE SENSE OF "NEED" WHICH APPEARS UNLIMITED - PRIORITIES MUST BE DETERMINED BY THE SERVICE AREA

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- COMMUNITY MENTAL HEALTH PROGRAMS (CONT'D)		COMMUNITY MENTAL HEALTH PROGRAMS NATIVE FRIENDSHIP CENTRES GP'S PUBLIC HEALTH NURSES, V.O.N. SOCIAL WORKERS IN HOSPITALS SOCIAL SERVICES DEPARTMENTS YMCA/YWCA'S PROGRAMS PROFESSIONALS IN PRIVATE PRACTICE RECOVERY INCORPORATED	
- OTHER LOCALLY DEVELOPED SERVICES		RESIDENTIAL HOMES FOR SPECIAL CARE - 92 BEDS IN 15 HOMES	ACCESS TO CASE MANAGEMENT SERVICES AND S.I.L. AS APPROPRIATE
6. ADULT HOSPITAL-BASED SERVICES			
- CRISIS INTERVENTION PROGRAMS	1-2 FORMAL PROGRAMS WITH 6-8 TOTAL STAFF	NOTHING FORMAL	1-2 FORMAL PROGRAMS WITH 6-8 TOTAL STAFF
	IN SMALL HOSPITALS - ALL STAFF TRAINED TO DEAL WITH CRISIS	COMMUNITY HOSPITALS OTHER PROGRAMS WITH A ROLE: NORTH BAY CRISIS HOUSE NIPISSING TRANSITION HOUSE N.B.P.H. STAFF AND SOCIAL WORKERS, OUT-PATIENT CHILDREN'S MENTAL HEALTH SERVICES C.A.S. ASSOCIATIONS FOR THE MENTALLY RETARDED PUBLIC HEALTH NURSES, V.O.N. FAMILY LIFE CENTRE INDIAN FRIENDSHIP CENTRE	TRAINING FOR COMMUNITY HOSPITALS AND OTHER AGENCIES WITH STRONG NETWORKING AND COMMUNICATIONS

CONTINUED...

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
- CRISIS INTERVENTION PROGRAMS (CONT'D)		FAMILY RESOURCE CENTRES RAPE CRISIS CENTRE OPP GPS HOMES FOR THE AGED, NURSING HOMES HOMES FOR SPECIAL CARE SOCIAL SERVICES DEPARTMENT	
- "ACUTE" PSYCHIATRY BEDS	49 BEDS - DISTRIBUTED BETWEEN NIPISSING/TIMISKAMING WITH 50-53 TOTAL STAFF	52 ACUTE CARE (AND CHRONIC) BEDS AT N.B.P.H. WITH STAFF ACUTE "SERVICES" PROVIDED BY GENERAL HOSPITALS THROUGHOUT THE AREA	7 BEDS IN NIPISSING 16 BEDS IN TIMISKAMING WITH TRAINING F STAFF 23 ADDITIONAL BEDS IN TOTAL
- GERIATRIC OUTREACH PROGRAM	2 FORMAL PROGRAMS WITH 4-5 TOTAL STAFF	NOTHING FORMALLY - N.B.P.H. OUT-REACH SERVICE	2 FORMAL PROGRAMS (1 NIPISSING/1 TIMISKAMING) WITH 4-5 TOTAL STAFF
- AMBULATORY CARE SERVICES	2 FORMAL SERVICES TO SUPPORT THE IN-PATIENT FUNCTION WITH 15-20 TOTAL STAFF	N.B.P.H. OUT-PATIENT SERVICE WITH STAFF	2 SERVICES (1 NIPISSING/1 TIMISKAMING) WITH A RANGE OF TREATMENT PROGRAMS - 15-20 TOTAL STAFF
- HOSTEL SERVICE	1-2 HOSTELS WITH 2-4 TOTAL STAFF	NOTHING	1-2 HOSTELS WITH 2-4 ADDITIONAL STAFF
7. CHILDREN'S ACUTE PSYCHIATRY BEDS	10 ACUTE CARE BEDS WITH 13-16 TOTAL STAFF	NOTHING	10 BEDS WITH 3.5 STAFF ON DAY/EVE; 1 R 2 CHILD CARE, 0.5 RECREATION THERAPIST; 1 RN AND CHILD CARE WORKER AT NIGHT (13-16 ADDITIONAL STAFF)
8. CHILDREN'S MENTAL HEALTH CENTRE	7-8 MENTAL HEALTH NURSES PLUS OTHER SERVICES CURRENTLY AVAILABLE	CONCORDIA CENTRE - NORTH BAY - 10 STAFF CHILD AND YOUTH SERVICES - TIMISKAMING - 5.3 STAFF	ESTABLISH PUBLIC HEALTH NURSES WITHIN THE SCHOOL SYSTEM - 7-8 SCHOOL-BASED MENTAL HEALTH NURSES

ESSENTIAL COMPONENTS IN THE SERVICE AREA (CONT'D)	2001 REQUIREMENTS	CURRENT SERVICES	NET ENHANCEMENTS/ADDITIONS
9. PSYCHIATRISTS	12 PSYCHIATRISTS FOR NIPISSING/TIMISKAMING 3 PSYCHIATRISTS FOR THE REGIONAL SERVICES	12.5 AT N.B.P.H. 1 PRIVATE PSYCHIATRIST IN NORTH BAY PART-TIME ROUYN PSYCHIATRIST CONSULTS IN TIMISKAMING	UP TO 1.5 ADDITIONAL PSYCHIATRISTS WIT RELOCATION THROUGHOUT THE DISTRICT
10. ADDICTIONS SERVICES PROGRAM COMPONENTS INCLUDE: - HEAD OFFICE - ASSESSMENT, REFERRAL, CASE MANAGEMENT - DAY TREATMENT PROGRAM - OUT-PATIENT PROGRAM - AFTER-CARE PROGRAM - DETOX BEDS - SUPERVISED RESIDENCES - COMMUNITY ADDICTIONS SERVICES WORKERS	ONE COMPREHENSIVE PROGRAM PER SERVICE AREA TO COMPLEMENT AND ENHANCE EXISTING SERVICES	NOTHING EXISTS IN THIS FORM CURRENTLY	SUDBURY ALGOMA PILOT FOLLOWED BY THE TAILORING AND ESTABLISHMENT OF A SERVIC WITH STAFF NIPISSING/TIMISKAMING REQUIREMENTS: 20-25 STAFF PLUS SPACE, EQUIPMENT AND DETOX BEDS
EXISTING SERVICES		ADDICTION RESEARCH FOUNDATION - 4 STAFF ALCOHOL AND DRUG ABUSE PROGRAM - ST. JOSEPH'S CENTRE (NORTH BAY) 15 BEDS WITH 7 STAFF HARMONY HOUSE - KIRKLAND LAKE, 4 STAFF COMMANDA HEALTH CENTRE - (STURGEON FALLS) 4 STAFF WORKERS NORTH BAY HALF-WAY HOUSE - MALE ALCOHOLICS (15) VITA WAY FARM - 16 BED, 2 STAFF (3 MONTH PROGRAM - YOUTH ADDICTIONS) TIMISKAMING ALCOHOL ASSESSMENT PROGRAM - TIMISKAMING HEALTH UNIT, 1.1 STAFF	LINKAGES TO THE COMPREHENSIVE PROGRAM A APPROPRIATE

however, these services are offered primarily in a hospital setting. As described under components of the model, the concepts behind the SAP Program should continue (e.g., relationship building) but skills should be learned in the community and preferably in the individual's own home or surroundings.

In Nipissing/Timiskaming 10 SIL workers are required, 3 should be fully bilingual/francophone and at least one native worker should be recruited.

High/Medium Support Housing

There is a great need to develop high/medium support housing in Nipissing/Timiskaming as nothing is currently available. It is mended that two homes with professional staffing be developed with a total of 15 beds. One of these homes might be considered for Kirkland Lake or the Tri-Town area depending upon which site is selected for the new designated psychiatry service with ambulatory care programs.

Drop-In Centres

There are two drop-in centres in this service area located in North Bay and Kirkland Lake. The North Bay centre is the most active drop-in centre in Northeast Ontario, designed to provide social/recreational opportunities to the chronic mentally ill individual, many of whom have been hospitalized previously at NBPH. Community Contact in Kirkland Lake is a much smaller program with mainly women attending the centre on a daily basis.

Under the proposed model, the CMHMB might choose to expand these two programs or introduce new drop-in centres in an area such as Sturgeon Falls, where francophone patients could benefit; or consider the Tri-Town area as a possible location.

Employment Programs

There is a vocational workshop operated in the City of North Bay offered jointly by NBPH and the Mental Health Services Board. In the future, as the chronic ex-psychiatric population is reduced, it should be possible to reduce the size of this function and possibly create a work site/function in Kirkland Lake or the Tri-Town area.

A job development program with 2 to 3 full-time staff who will generally work in the larger population centres is also required. Relationships should be developed between mental health workers and organizations such as Canada Employment Centres, Boards of Education and community colleges such as

Seven Arrows Learning Centre so that high potential individuals may access appropriate programs.

Residential Homes for Special Care

Residential homes for special care provide room and board for discharged psychiatric patients as funded by the Ministry of Health. Existing homes should be considered as part of the range of housing available to individuals with chronic mental disabilities. Case managers should work with home operators, as they would private superintendents and boarding home operators to provide support and assistance and to maintain the client at his/her optimal level of function. SIL workers will go into the residential home for special care if this is an aspect of the individual's treatment plans. There are currently 92 beds in 15 homes in the North Bay area.

Crisis Intervention Programs

There are no formal crisis intervention programs in Nipissing/Timiskaming hospitals. There are, however, a variety of agencies and organizations involved in crisis services such as the North Bay Crisis House, Nipissing Transition House, hospitals, NBPH, public health nurses and a range of children's providers. As well, the Family Life Centre in North Bay, Indian Friendship Centre, OPP, GPs and elderly care providers all report that they have a role.

Under this model, 1 or 2 formal programs are recommended which are hospital-based. Programs will likely be located at the site of designated services where trained mental health professionals will be concentrated. The formal programs with trained staff should take leadership roles in educating other hospitals throughout the service area to deal with mental health and other types of crisis. They could also assist mental health workers in small communities to develop policies and producers for dealing with crisis.

As shown in Exhibit 31, many providers and agencies deal with crisis situations and could benefit from strong working relationships with formal crisis programs.

Acute Psychiatry Beds

There are 26 psychiatry beds at NBPH for Timiskaming/-Nipissing/ Parry Sound. They are not highly utilized and other hospitals were previously shown to also provide acute services.

The service area requires 49 beds to be distributed as follows:

- 33 beds in Nipissing (at the New North Bay District Hospital); and a
- 16 bed service in Timiskaming.

This is almost double the current number of designated beds (26) for the service area.

Geriatric Outreach

This program requires 4 to 5 professional staff assisted by a psychiatrist. The program will likely be based out of the new psychiatric North Bay Hospital with out-reach provided by workers who may travel to smaller communities. The CMHMB should consider locating one specialist in Timiskaming.

Ambulatory Care Services

These services are recommended to provide active treatment programs to support the acute psychiatry services. Programs will be available to patients who travel a distance to receive services or to individuals in the community who live at home and commute to services.

Currently, the NBPH has an out-patient clinic in the city of North Bay. Services suggested under this model will be more numerous with access for in-patients as well as out-patients and will therefore, be required to be on the hospital site.

Two ambulatory care services are recommended to support the designated hospital services in Nipissing and Timiskaming.

Hostel Service

One or two hostels are required to accommodate patients involved in ambulatory care who may travel a distance, yet not require hospitalization.

Children's Acute Psychiatry Beds

There are no such beds in Nipissing/Timiskaming currently. Ten beds with staff are recommended and will likely be developed at/near the new North Bay District Hospital. As discussed previously this service should result in a major improvement to services for children in the service area. A child psychiatrist or psychiatrist with experience in working with children should be recruited in order to offer this service.

Children's Mental Health Centres

The Concordia Centre in North Bay and Child and Youth Services of Timiskaming are important elements and strengths in the mental health system. Enhancements to the services of children's mental health centres in all service areas are suggested with the introduction of public health nurses working in mental health within the school system.

Psychiatrists

Based on a standard of 1 psychiatrist per 10,000 general population, the Nipissing/Timiskaming area has a sufficient number of psychiatrists considering the current number at NBPH. The issue will be the redistribution of such resources with the reduced number of beds at the Regional Psychiatric facility. For example, Timiskaming could potentially recruit 4 psychiatrists based on this standard. It should be noted, however, that the model proposed is not dependent upon psychiatrists and recommends GPs be trained and developed to deal with the supportive, on-going maintenance needs of chronic psychiatrically disabled individuals in their communities. At least 4 of the psychiatrists for Nipissing/Timiskaming should be bi-lingual and it would be optimal if the 3 psychiatrists to direct the new regional psychiatry services were all bi-lingual.

Addictions Services

As discussed, Nipissing/Timiskaming has several addictions services offering various types of assessment and treatment programs including the Alcohol and Drug Abuse Program at St. Joseph's Hospital in North Bay, Harmony House, the Vita Way Farm and a new Timiskaming Health Unit alcohol assessment program.

The Sudbury Algoma model offers a comprehensive range of treatment options which could also be introduced and tailored to the needs of Nipissing/Timiskaming to complement current services. Such a service could be based in North Bay for example, with addictions services workers in communities such as Sturgeon Falls, Kirkland Lake, and the Tri-Town area to provide more local services and appropriate referrals to the more comprehensive program in North Bay. It has been recommended that the Sudbury Algoma program be approved and that this pilot experience be considered as other service areas begin to plan and implement their programs over the next 3 to 4 years.

Implementation Considerations

Providers and agencies in Nipissing/Timiskaming suggested that the following major obstacles will need to be addressed in implementing a new mental health services model. These obstacles are ranked in order of response frequency.

- 46% said lack of funding;
- 18% said lack of personnel; and
- 16% reported lack of communication.

These were the top 3 responses to this question. Some of the other obstacles identified by respondents include distance and isolation, public attitudes, unclear provider roles, inter-agency competition/rivalry and distance and isolation.

Some of the major implementation activities will be:

- establishing a CMHMB and preserving the strengths of current services - e.g., making arrangements with the Public Health Units to establish reporting relationships and lines of accountability for nurses who will continue to perform an essential case management function;
- education and promotion of the model to prepare the public for the model and its service components;
- overall redefinition of treatment and accommodation functions by providers to match the requirements of the model;
- planning the redevelopment of the regional psychiatry services and the redistribution and retraining of NBPH staff to fulfill new roles in the system;
- individual treatment planning and selective de-institutionalization of NBPH patients, and offering the client the opportunity to return to their home area;
- development of adult acute psychiatry services in North Bay and in a Timiskaming Hospital with ambulatory care, hostel and crisis intervention programs as appropriate;
- planning of children's acute psychiatry services and recruitment of children's experts;
- recruitment and retention of francophone and native mental health workers and by 2001 a target should be 65 to 76 bi-lingual or francophone mental health workers and 8 native workers in key positions;

- education and training of mental health workers throughout the service area;

- establishing appropriate levels of housing to meet the needs of Nipissing/Timiskaming residents; and

- over time possibly reducing the number of workers in North Bay in order to enhance/reallocate services to other parts of the service area since the psychiatric population may decline as the service areas introduce program, housing and other support services.

As well, a decision should be taken as to whether the area will develop a District Health Council. Under this model, it is recommended that the District Health Council be used for overall planning of mental health services and to make recommendations to the Ministry of Health on priorities. Furthermore, the "Northeast Regional voice" is recommended as a joint function of the mental health sub-committees of District Health Councils. In light of these roles, it would seem timely for Nipissing/ Timiskaming to organize formally with a District Health Council.

Another important implementation consideration which warrants specific discussion here is:

- the recommendation that Nipissing and Timiskaming work together as one service area to deliver mental health services in a co-operative and effective manner under one CMHMB.

Traditionally, the two areas have been independent of each other. During this study, a strong case was made by the Steering Committee representative from Timiskaming that the area be considered as a separate service area. The major reasons for the request were that:

- Timiskaming is a recognized "political" district with its own territory/boundaries;

- Timiskaming has developed an excellent community support system for its residents with mental health disorders - the case management program of the Timiskaming Health Unit is second to none in the Northeast. This approach to care is unique and distinct from that offered in Nipissing.

- The Ministry of Community and Social Services recognizes Timiskaming as a separate and unique "district" and funds a Children's Mental Health Centre for Timiskaming children.

- Providers believe that mental health services planning is more successful on a smaller scale than that proposed under a CMHMB.
- Timiskaming providers believe they will lose much of what has been developed if combined with the larger area of Nipissing with 80,000 population.

The Steering Committee considered the concerns of Timiskaming but felt that Timiskaming should still be considered as part of a Nipissing/Timiskaming service area. One reason for this decision is that the Ontario Ministry of Health requires a minimum population of 100,000 for the establishment of a formal planning body, District Health Council and as a reasonably sized planning area. The combined areas of Nipissing/Timiskaming represent 120,000 total population. The Steering Committee further recognizes the strengths which exist already in Timiskaming and that the case management program is the most advanced program in the region. It therefore, has potential to serve as a model, not only for Nipissing, but also for other parts of the Northeast. The Committee believes that providers from Timiskaming can and should take on a leadership role which will be a major asset to the CMHMB in the challenging implementation of this model throughout the Nipissing/ Timiskaming service area.

* * * * *

As shown in Exhibit 21, Summary Positions in Mental Health, the Nipissing/Timiskaming service area has an estimated 77 to 78 workers who are in organizations other than NBPH. This number will be increased under the model to 232 to 272 workers, focused only on services to residents of Nipissing/Timiskaming. The staffing for the service area may cost as much as $9.5 million a year. This figure excludes the staffing for the new Regional Psychiatry service in North Bay.

THE SPECIAL CASE OF PARRY SOUND

For reasons discussed previously, this study does not make specific recommendations for Parry Sound. It is reported that Parry Sound/Muskoka may be organizing with its own District Health Council which can take significant time to implement. The model of mental health proposed for Northeast Ontario is considered to be flexible enough for adaptation to such an area in the sense of the essential components of mental health services suggested for each service area. This does not, however, negate the requirement for regional services such as continuing care, developmentally handicapped services and forensic services, which could be offered by either Penetanguishine or NBPH. There is no such provision in this model currently for the 70,000 to 80,000 residents of Parry Sound/Muskoka and if the new Northeast Regional facility is expected to provide care for these residents, additional services must be planned.

As well, the 33 acute psychiatry beds to be located in North Bay are planned for Nipissing only. Based on a standard of 0.4 beds/1,000 population, the Parry Sound/Muskoka area may require a total of 32 beds to meet the needs of its residents for acute psychiatry care.

It will be important for the Ministry of Health to make a decision promptly around implementation of the total model for Parry Sound/Muskoka as well as decide whether referrals for regional services will be south to Penetanguishine or to North Bay. Continued admissions to North Bay beds would add unnecessary pressure to a system which already has ambitious targets to keep hospital beds to a minimum.

VIII. IMPLEMENTATION OF A COMPREHENSIVE MENTAL HEALTH SYSTEM

This report is intended to provide a starting place and vision for a comprehensive and balanced system of mental health care for Northeast Ontario. As discussed throughout, one major thrust is towards developing reasonable self-sufficiency within the four service areas by ensuring that an essential continuum of services is in place and accessible to all residents.

To this end, one challenge will be to build upon existing strengths and the expertise of current providers. The fact that each service area begins at a different starting place means that flexibility and creativity is required in applying the model. For this reason, the proposed implementation is complex in that the four service areas each face their own unique challenges. Algoma and Cochrane must expand their acute hospital psychiatry services; Manitoulin/Sudbury must negotiate reductions in beds. Nipissing/Timiskaming is challenged to develop a comprehensive health complex in North Bay and re-distribute resources to Timiskaming which has one-third of the service area population. Enhancements to community-based services are required across all areas.

Implementation, as depicted in Exhibit 32 will likely take 8 to 10 years from start-up. The timeframe, however, is highly dependent upon the establishment of annual goals and initiatives which are supported by a sufficient level of funding from the Ministry of Health. The first year will be critical to successful implementation.

NORTHEAST MENTAL HEALTH STUDY IMPLEMENTATION COMMITTEE

It is recommended that implementation planning begin with the appointment of a Northeast Implementation Committee (NIC) to oversee implementation.

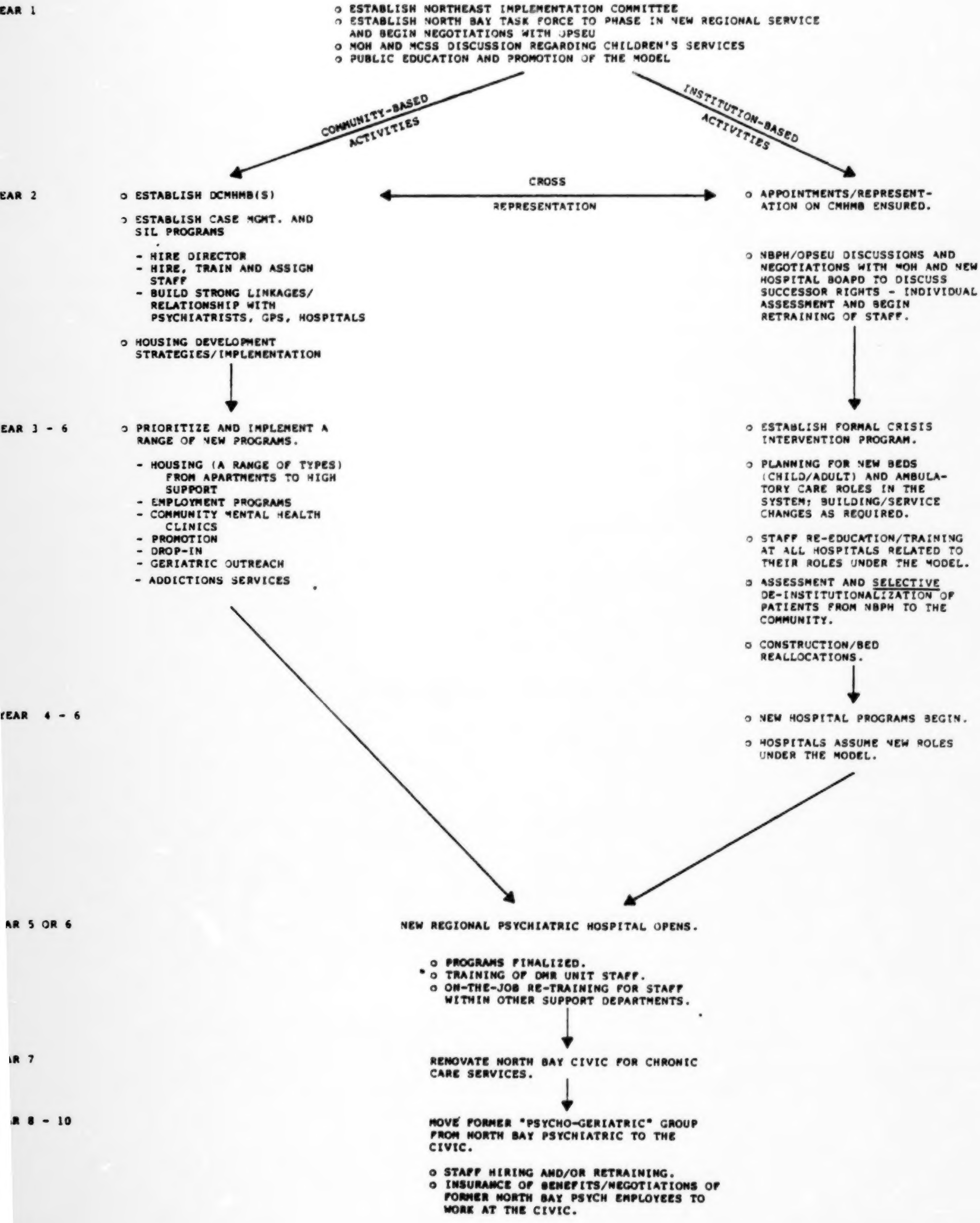
At the outset, the NIC will be responsible for developing a more detailed implementation plan and timing, and work towards establishing the four Community Mental Health Management Boards (CMHMBs). The Committee will work extensively with the three District Health Councils and major mental health providers to ensure appropriate appointments to the CMHMB and will have significant input to the hiring of Executive Directors.

This Committee should undertake a human resources study to identify needs for recruitment outside the Northeast, to supplement the current mental health workers, and to develop orientation courses and educational programs to ensure

EXHIBIT 32

IMPLEMENTATION PLAN

NORTHEAST ONTARIO MENTAL HEALTH SYSTEM



EAR 1

- o ESTABLISH NORTHEAST IMPLEMENTATION COMMITTEE
- o ESTABLISH NORTH BAY TASK FORCE TO PHASE IN NEW REGIONAL SERVICE AND BEGIN NEGOTIATIONS WITH OPSEU
- o MOH AND MCSS DISCUSSION REGARDING CHILDREN'S SERVICES
- o PUBLIC EDUCATION AND PROMOTION OF THE MODEL

EAR 2

- o ESTABLISH DCMHMB(S)
- o ESTABLISH CASE MGMT. AND SIL PROGRAMS
  - HIRE DIRECTOR
  - HIRE, TRAIN AND ASSIGN STAFF
  - BUILD STRONG LINKAGES/RELATIONSHIP WITH PSYCHIATRISTS, GPS, HOSPITALS
- o HOUSING DEVELOPMENT STRATEGIES/IMPLEMENTATION

- o APPOINTMENTS/REPRESENTATION ON CMHMB ENSURED.
- o NBPH/OPSEU DISCUSSIONS AND NEGOTIATIONS WITH MOH AND NEW HOSPITAL BOARD TO DISCUSS SUCCESSOR RIGHTS - INDIVIDUAL ASSESSMENT AND BEGIN RETRAINING OF STAFF.

EAR 3 - 6

- o PRIORITIZE AND IMPLEMENT A RANGE OF NEW PROGRAMS.
  - HOUSING (A RANGE OF TYPES) FROM APARTMENTS TO HIGH SUPPORT
  - EMPLOYMENT PROGRAMS
  - COMMUNITY MENTAL HEALTH CLINICS
  - PROMOTION
  - DROP-IN
  - GERIATRIC OUTREACH
  - ADDICTIONS SERVICES

- o ESTABLISH FORMAL CRISIS INTERVENTION PROGRAM.
- o PLANNING FOR NEW BEDS (CHILD/ADULT) AND AMBULATORY CARE ROLES IN THE SYSTEM; BUILDING/SERVICE CHANGES AS REQUIRED.
- o STAFF RE-EDUCATION/TRAINING AT ALL HOSPITALS RELATED TO THEIR ROLES UNDER THE MODEL.
- o ASSESSMENT AND SELECTIVE DE-INSTITUTIONALIZATION OF PATIENTS FROM NBPH TO THE COMMUNITY.
- o CONSTRUCTION/BED REALLOCATIONS.

EAR 4 - 6

- o NEW HOSPITAL PROGRAMS BEGIN.
- o HOSPITALS ASSUME NEW ROLES UNDER THE MODEL.

AR 5 OR 6

NEW REGIONAL PSYCHIATRIC HOSPITAL OPENS.

- o PROGRAMS FINALIZED.
- o TRAINING OF DMR UNIT STAFF.
- o ON-THE-JOB RE-TRAINING FOR STAFF WITHIN OTHER SUPPORT DEPARTMENTS.

AR 7

RENOVATE NORTH BAY CIVIC FOR CHRONIC CARE SERVICES.

AR 8 - 10

MOVE FORMER "PSYCHO-GERIATRIC" GROUP FROM NORTH BAY PSYCHIATRIC TO THE CIVIC.

- o STAFF HIRING AND/OR RETRAINING.
- o INSURANCE OF BENEFITS/NEGOTIATIONS OF FORMER NORTH BAY PSYCH EMPLOYEES TO WORK AT THE CIVIC.

appropriate retraining. Under the proposed model it is estimated that 200 to 360 new jobs will be generated throughout Northeast Ontario with full implementation.

A NORTH BAY TASK FORCE

At the same time as the NIC is established, representatives from the Ministry of Health (Institutional Operations and Mental Health Branch) and the Ministry of Government Services, with representatives from the North Bay Psychiatric Hospital Community Advisory Board and Management, OPSEU and other providers in the service area should work together to plan the new regional psychiatric service. It will also be necessary for the task force to identify redeployment, retraining and other options such as early retirement which may be desirable to current North Bay Psychiatric Hospital staff. Negotiations between the union and the Ministry must begin within the first year to address OPSEU concerns around successor rights and job security and to develop a strategy to address such concerns.

* NBPH Staff Redeployment

As shown in Exhibit 33, there are currently 489 staff at the North Bay Psychiatric Hospital for the 308-bed facility. For purposes of this exhibit, redeployment options reflect the number of jobs which could be available to NBPH staff, currently occupied positions are excluded.

Under this scenario there should be a sufficient number of jobs in the Nipissing/Timiskaming service area alone, to accommodate the North Bay staff. In fact, there will be a net increase in available jobs, (15 to 50 positions) based on 504 to 538 jobs for 489 current staff. If one considers the attrition rate of 7 persons or 1.5% a year reported by the Hospital, in 10 years, natural attrition would leave only 420 NBPH staff available for mental health roles with vacancies for 84 to 118 new workers.

It should be noted that the trend will be towards more professional and para-professional roles and fewer support positions (housekeeping, dietary, maintenance, etc.). This is due to the emphasis on community-based programs, away from a hospital focus. The support jobs which will remain include 112 at the new psychiatric service and 56 which should transfer to the North Bay Civic site.

This estimàte is conservative as it does not include other jobs which will become available throughout the Northeast mental health system (in Algoma, Cochrane or Manitoulin/Sudbury) or positions which might also become

EXHIBIT 33

STAFFING ISSUES: NORTH BAY PSYCHIATRIC HOSPITAL

	CURRENT STAFF	BEDS	RATIO
	489*	308	1.58
PROFESSIONALS/PARA PROFESSIONALS	266	---	0.86
SUPPORT STAFF	223	---	0.72

	REDEPLOYMENT OPTIONS WITHIN NIPISSING/TIMISKAMING		
	PROFESSIONALS	SUPPORT	TOTAL POSITIONS
"NEW" PSYCHIATRY SERVICES	133	112	245
ADULT COMMUNITY BASED-SERVICES	39-55	---	78-96
ADULT HOSPITAL BASED-SERVICES	77-90	---	77-90
ADDICTIONS SERVICES	20-25	---	42-47
CHRONIC CARE FACILITY	67	56	123
	336-370	168	504-538

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* Current attrition rates of 7 persons per year indicate that by year of full implementation (in 10 years), there will be approximately 420 NBPH staff still in the system.

available at the new North Bay District Hospital. It is recommended that NBPH staff be given priority in applying for mental health positions which become available in all service areas.

- **Individual Accountability**

Another priority in year 1 is that individual employees at NBPH and mental health workers across the Northeast should carefully review the proposed direction for future services. It will be important for each individual to identify potential roles for themselves in the system. In cases where additional education is required, the employee should take initiative in attending appropriate programs or courses and assume primary responsibility for their future role in the mental health system.

In support of employee initiatives, it is suggested that the Director of Education at NBPH assume a leadership role to assist employees to upgrade their skills and that the Director should be a key individual, working with the NIC in developing appropriate training programs, throughout the Northeast along with the newly appointed Co-ordinator from the University of Western Ontario.

PUBLIC EDUCATION AND PROMOTION

A very important start-up and ongoing function will be public education and promotion regarding the proposed philosophy of treatment for chronically mentally ill individuals. Under the model, more of these individuals will be able to live in their own communities. The tendency to send everyone to North Bay will be curtailed in light of the highly specialized regional role which is suggested. In areas where zoning has been a problem, such as Timmins, promotion will be especially important to ensure that these individuals will have access to appropriate housing.

Following the first year of implementation, the CMHMBs asnd other local providers have more of the responsibility to develop the mental health system.

COMMUNITY MENTAL HEALTH MANAGEMENT BOARD (CMHMB)

Once established, the CMHMB in each service area will hire an Executive Director, financial and clerical support staff. In developing the community-based system, it will be a priority to establish the case management and SIL programs. With these programs in place, important linkages within the continuum of hospital/community-based services will begin.

The case manager should become the designated "team leader" for the mental health professionals involved in the client treatment plan.

It was discussed earlier that some service areas have received specific funding for case management programs. This has been mainly through initiatives of public health units. Some programs, such as the Timiskaming Case Management Program are considered to be important strengths within the service area which should be preserved through implementation.

In cases where programs already exist, there will be a need for shared accountability. Primary accountability should be to the Public Health Unit from the professional and service component of the program with accountability also to the CMHMB to ensure the appropriate role of the program and evaluative mechanisms in place. The reader should remember the number of case managers required for implementation and that the role of case management in small communities may be fulfilled by an individual prepared as a generalist mental health worker and may not be a public health nurse.

Case managers will be instrumental in developing other program plans, especially in the area of housing. With various levels of housing in place, (apartments, group homes and high/medium support housing), even as early as three years into implementation, it may be possible to bring selected patients out of NBPH into alternative living settings.

It will likely take another 2 to 3 years to establish the full range of community programs including geriatric outreach, promotion programs and drop-in centres. These services should all be in place around the time that the new North Bay Hospital is to open.

HOSPITAL-BASED IMPLEMENTATION ACTIVITIES

The NIC will play an important role in overseeing the timely implementation of the model in the hospital-based services of the mental health system.

In some areas, hospitals are recognized as the current leaders in developing community-based services. This includes organizations such as the Sudbury Algoma Hospital with its community mental health clinics network. Such organizations should lend their expertise and participate actively in the service area implementation.

By year 3, designated hospitals will be establishing formal crisis intervention and geriatric outreach programs. With funding approval in place, start-up of these programs means that the right professionals have been recruited and that the programs have established goals, objectives and evaluative mechanisms and standards in place. Planning for new/reduced acute psychiatry in-patient services and comprehensive ambulatory care programs will be a more lengthy process as there are facility/space implications and staffing requirements for these activities. Plans in year 3 should ensure funding approval and programs which will occur in years 4 to 6. In some places such as the Sault Ste. Marie Plummer Memorial Hospital and in Timmins St. Mary's Hospital, there will likely be requirements for new construction to accommodate the hospital-based services suggested under this model.

Smaller hospitals which will assume new roles in North Cochrane, Timiskaming and Elliot Lake will similarly need to plan their services.

In the sense of training programs the NIC human resources study will need to include an inventory of the staffing requirements in the smaller hospitals to the extent of staff retraining requirements as identified by the North Bay Task Force for NBPH.

FINAL STEPS IN IMPLEMENTATION

Within 6 years of implementation start-up, the service areas should have assumed their new roles under the model. Housing, case management and SIL programs will be working and the regional psychiatry facility will be opening in North Bay on the new North Bay District Hospital site. The role of the new regional psychiatry service will have been defined and individual patients assessed as to their needs for continued hospitalization.

As mentioned before, as early as year 3 of implementation, some of the current psychiatric patients at NBPH could have treatment plans and a case manager to enable them to live in the community. Some patients may want to return to their home service area in light of the services which will be available. In any event, individual patient assessment by a team of professionals including a case manager, psychiatrists/GPs, nurses and social workers should be conducted and re-evaluated on an on-going basis.

The opening of the new regional psychiatry service and new District Hospital requires the 78-bed "psycho-geriatric" unit to remain at the NBPH until renovations of the Civic site can be completed. By year 8, it should be possible to close the current NBPH site.

COSTS

In 1983/84, the Northeast Ontario Region received $47.6 million for adult mental health services. This included major funding to the NBPH, general hospital psychiatry services and community mental health programs and homes for special care. A small portion was for OHIP payments.

The proposed model requires a significant financial investment on the part of the Ministry of Health. It is estimated that a capital investment of $60 to $70 million is required to ensure an appropriate level of hospital-based services are in place. This includes an additional 36 beds for Algoma, 33 beds in Cochrane, 80 beds in Manitoulin/Sudbury. This cost includes approximately $40 million to build the new regional psychiatry facility and North Bay acute psychiatry services for a total of 155 beds and to renovate the Civic Hospital for 78 geriatric patients.

Annual operating costs are estimated relative to staffing of the mental health system, considering both hospital and community-based services. As shown in the following Exhibit 34, it is estimated that there are currently 1,146 to 1,162 mental health positions in the system, 605 of these positions or half are dedicated to regional services.

By year 2001 there will be an estimated 1,336 to 1,525 mental health positions, including several Ministry of Community and Social Services funded services, such as family life centres, children's mental health centre and children's acute care beds, an increase of 193 to 360 overall. The estimated cost related to these enhancements $6.7 to $12.7 million based on an average annual salary of $35,000.

Annual staffing costs are estimated at $46.8 to $53.4 million including $600,000 a year to operate four Community Mental Health Management Boards.

The enhancements to the service areas is well illustrated here. While regional functions are shown with significantly reduced staffing and associated costs, the service areas all receive enhancements. Regional service costs are reduced approximately $12 million, with $18 to $25 million to be used specifically to enhance the more locally focused services.

EXHIBIT 34

COST ESTIMATES: STAFFING THE "NEW" MENTAL HEALTH SYSTEM

	Year 2001 Total Requirement		Current Resources		Additional Requirement	
Service Areas	Staff	$*	Staff	$*	Staff	$*
Algoma	259-305	9.1-10.7	112-119	3.9-4.2	147-186	5.2-6.5
Cochrane	221-265	7.7- 9.3	95-98	3.3-3.4	126-167	4.4-5.9
Manitoulin/Sudbury	366-422	12.8-14.8	257-262	9.0-9.2	109-160	3.8-5.6
Nipissing/Timiskaming	232-272	8.1- 9.5	77-78	2.7	155-194	5.4-6.8
Sub-total	1078-1264	37.7-44.3	541-557	18.9-19.5	537-707	18.8-24.8
Regional Services						
Adult (NBPH)	245	8.6	478	16.8	(233)	(8.2)
Children's (SA)	13-16	0.5-0.6	127	4.4	(114-111)	(3.9-3.8)
Sub-total	258-261	9.1-9.2	605	21.2	(344-347)	(12.0-12.1)
GRAND TOTAL	1336-1525	46.8-53.4	1146-1162	40.1-40.7	193-360	6.7-12.7

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* In millions based on an average annual salary of $35,000.

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APPENDIX A

RECOMMENDATIONS OF THE 1981 NORTHEAST ONTARIO MENTAL HEALTH STUDY JOINT TASK FORCE

RECOMMENDATION 1

A Northeastern Ontario Regional Mental Health Services Committee should be formed with representatives from the District Health Councils, North Bay Psychiatric Hospital and the Districts of Nipissing, Parry Sound and Timiskaming and representatives from the Ministry of Health and the Ministry of Community and Social Services to plan mental health services in the Northeastern Region of Ontario.

Each District Health Council is encouraged to establish a mental health committee, subcommittee or task force with membership drawn from within the Councils and from other interested persons presently involved in the delivery of mental health services. A Northeastern Ontario Mental Health Services (NOMHS) Committee should then be formed with membership drawn from the Mental Health Committees established by each of the District Health Council's, from the North Bay Psychiatric Hospital and from concerned citizens in areas without District Health Councils.

RECOMMENDATION 2

The Northeastern Ontario Regional Mental Health Services Committee should have the primary responsibility of co-ordinating the planning of acute and chronic psychiatric services which cross jurisdictional and ministerial boundaries and the District Health Councils should have the primary responsibility for planning of community mental health programs and support services which are more localized.

The North Bay Psychiatric Hospital provides intermediate and long-term hospital services for the chronically mentally ill, across the Northeast. The Sudbury-Algoma Hospital also has the responsibility of providing mental health services to children and adolescents from across the Northeast as well. The North Bay Psychiatric Hospital, the Sudbury-Algoma Hospital, the Sudbury General Hospital, the Plummer Memorial Hospital (Sault Ste. Marie), St. Mary's General Hospital (Timmins), and the Sensenbrenner Hospital (Kapuskasing) are principally responsible for providing acute psychiatric care services to the patients in their more immediate community.

The Regional Committee would therefore co-ordinate the planning of Intermediate and Long-Term hospital-based mental health services for adults and children. The District Health Councils would continue to co-ordinate the planning of more localized acute mental health services including crisis intervention, maintenance and community based support services. The interface between the two, would be the joint planning of community-based services in support of psychiatric services and follow-up care following hospitalization.

RECOMMENDATION 3

The organization and administration of mental health services for adults and children should be integrated.

Northern Ontario is faced with a critical shortage of mental health personnel and other resources. The fragmentation of mental health services exacerbates the situation through the inefficient use of these limited resources. The children's mental health and adult mental health services are evolving independently of each other under separate ministries, even though they tend to serve members of the same family. Apart from the Sudbury-Algoma Hospital, there is virtually no sharing of personnel, office space or consultants and purchase of service agreements from existing agencies are rare. It is imperative that this fragmentation be eliminated as soon as possible.

RECOMMENDATION 4

Consideration should be given to decentralizing the administration of the Home for Special Care Program with the local psychiatric facilities assuming greater responsibility for the maintenance and on-going supervision of the patients in this program.

In Appendix Seven, a number of questions were raised about the Home for Special Care Program, which is administered for Northeastern Ontario by the North Bay Psychiatric Hospital. We encourage each District Health Council to discuss this issue with the Program Director at the North Bay Psychiatric Hospital, the nursing and residential homes which participate in the program throughout their District, and with local mental health providers to assess the situation in their own area. The NOMHS Committee could then play an important role by providing a forum in which to share the findings of the respective District Health Council's and to co-ordinate the planning and implementation of changes in the Home for Special Care Program, if changes are indicated and justified.

RECOMMENDATION 5

A mental health information system should be developed and maintained exclusively for tracking and monitoring the post-hospital care for the chronically mentally ill.

Once the chronically mentally ill are released from the hospital and returned to their communities, the co-ordination of their care is uncertain. The information system would contain the name, address, age, sex, diagnosis, for follow-up care. The persons or agency responsible for this follow-up care, or other professionals would be responsible for submitting periodic update on the patient's progress and care. The patient would stay on the system until they no longer require care.

The system could be designed in co-operation with the Department of Psychiatry at the University of Western Ontario and co-ordinated with the *hospitals and persons responsible for follow-up care who received statistical reports periodically on their patients and all other patients. In accordance with the recommendation of the Krever Report, the confidentiality of the patient should be assured and access to the information should be strictly controlled. The system should be located at the North Bay Psychiatric Hospital.*

RECOMMENDATION 6

North Bay Psychiatric Hospital should be designated as the regional centre for long-term care, back-up support for local mental health services and the treatment of difficult patients.

This recommendation serves to affirm the expertise and leadership of the North Bay Psychiatric Hospital and to facilitate the development of the resources they offer the region. The study presently being completed by the North Bay Psychiatric Hospital should serve to define this role in Northeastern Ontario.

Recommendation 7

Incentives and opportunities for participating in structured continuing educational programs should be created for mental health professionals in Northeastern Ontario.

Considering the difficulties of recruiting and retaining qualified health professionals in the North, mental health professionals serving in Northeastern Ontario should be provided reasonable opportunities to participate in appropriate continuing education programs, not only to keep them abreast of developments in their field of expertise, but also to reduce their isolation. The opportunities should include release time from work, with pay, and provide reimbursement of registration fees and necessary travel expenses.

Emerging ties with the University of Western Ontario, school of medicine, and the development of telecommunication system are two possibilities that have potential for alleviating part of this problem.

Recommendation 8

The quality of care and the quality of life of the chronically mentally ill patients should be assessed.

The study should be commissioned by the NOMHS committee in co-operation with the District Health Council's and the North Bay Psychiatric Hospital. An advisory committee, of representatives of the Hospitals, other major providers and the chronically mentally ill should review the goals, objectives, and proposed methodology for this study. This latter group should also be asked to comment on the findings of this study and to make recommendations.

RECOMMENDATION 9

A study for improving access to mental health services in disadvantaged areas should be jointly undertaken by the Northeastern Ontario Mental Health Services Committee and the District Health Councils.

Each district has communities and areas that are disadvantaged and they tend to be distant from the communities where the majority of mental health services are located. Priority should be given, immediately, to improve access to primary mental health services. Even though the planning should be completed in co-operation with psychiatrists and hospitals, the realities are that they will probably be involved in the consultation and support of community mental health services rather than the direct provision of them. Innovative and alternative forms of services will be required.

RECOMMENDATION 10

The District Health Councils should work with interested individuals in the communities to assess and to plan services for the promotion of mental health, prevention of mental health problems, and the early detection of mental illness.

While priority has been given in earlier recommendations to the provision of a basic range of acute and chronic psychiatric services, a comprehensive mental health system includes services for the promotion of mental health, prevention of mental health problems and the early detection of mental illness, as noted by the Ontario Council of Health Committee on Mental Health Services.

Programs for promotion, prevention and early detection are generally based in the community and built upon the resources available in the communities they serve. The assessing and planning of these services should be the responsibility of the District Health Council.

RECOMMENDATION 11

A special planning committee consisting of representatives from Band Councils, the Northeastern Mental Health Services Committee, provincial and federal officials should be struck to assess, plan and improve mental health services for the native people.

Because of the widespread distribution of native people throughout the Northeast, the variation in their treaty status, their particular social and economic status, and the federal responsibilities for health care, a separate planning and co-ordinating mechanism is recommended for the native people. This committee should be formed at the first opportunity.

RECOMMENDATION 12

Special efforts should be made to recruit and retain psychiatrists, psychologists and social workers to Northeastern Ontario, with a special emphasis for recruiting French speaking psychiatrists and psychologists.

There continues to be a shortage of mental health professionals in the region, and recruitment procedures are necessary to assure a continuity of services and program. While there are mental health services for francophones in the region, there is a shortage of psychologists and psychiatrists who can work with francophones in their mother tongue.

RECOMMENDATION 13

Establishment of professional relationships between psychiatrists and hospitals in Northeastern Ontario with the Department of Psychiatry at the University of Western Ontario should be encouraged and supported by the District Health Councils and the Ministry of Health.

There have been a number of attempts to establish relationships between providers in the Northeastern region and a health sciences centre. The ties of North Bay Psychiatric Hospital and the Sudbury-Algoma Hospital with Western and the telecommunication links between Sudbury and London are the most promising to-date.

The University of Western Ontario could contribute substantially to the recruiting and continuing education of mental health professionals, planning mental health services, and the evaluation of mental health care provided in the region. The potential benefits warrant support sufficient for them to be realized.

APPENDIX B

TERMS OF REFERENCE FOR THE STUDY

REQUEST FOR PROPOSAL

NORTHEASTERN ONTARIO

MENTAL HEALTH NEEDS ASSESSMENT STUDY

Background

World-wide trends directed towards enhancing mental health care increasingly emphasize local hospital-based services for both in-patients and out-patients as well as community-based mental health programs. There is a concomitant decreased emphasis on large regional in-patient facilities, distant from patients' homes, which isolate the patients from familiar family and community support systems.

Such support systems require community out-reach, follow-up, and rehabilitation services linked with treatment programs in order to facilitate the re-integration of discharged psychiatric patients into the community.

The Ontario Ministry of Health is now considering the future of North Bay Psychiatric Hospital in terms of role, function, physical plant, and location. In order to ensure that re-development of the hospital and concurrent development of services throughout its catchment area are consistent with the highest standards of modern mental health care, the Ministry wishes to commission a study of mental health needs and services across northeastern Ontario.

The mental health needs assessment study should, therefore, review all in-patient and out-patient services as well as all community based mental health programs in northeastern Ontario and recommend the best distribution of these services across the region.

Terms of Reference

1. The final report shall include:

   A. Detailed description of existing mental health services throughout northeastern Ontario.

      - institutional and community based services, whether or not the services fall within the jurisdiction of the Ministry of Health, e.g., children's services

      - facilities located outside the area but serving the population should also be included

   B. Detailed identification of mental health needs from a client-centered perspective.

C. Suggested stragety for meeting mental health needs, in the context of a continuum of care, including number, size, location, type and distribution of required resources to the year 2000.

2. The study should address the following issues, among others:

   - acute and chronic mental health needs
   - services for specific target populations, e.g. francopnones, natives, psychogeriatrics
   - possible integration and coordination of adult and children's mental health services
   - addiction services
   - institutional and community based service requirements to respond to identified needs in four key areas (North Bay, Sault Ste. Marie, Timmins, and Sudbury)
   - the future of North Bay Psychiatric Hospital i.e. role, size, location, and university affiliation.

3. The review of existing community-based services and identification of future requirements should include housing for former psychiatric patients, counselling, outreach programs, vocational services, etc.

4. Particular attention should be paid to issues of assessment, coordination and follow-up including requisite linkages between institutional and community care with respect to aftercare.

5. Attention should be directed to:

   - how to make more effective use of existing services through adjustments to the system, such as organizational changes, improved coordination, and elimination of duplication
   - the identification of client needs which can only be met through new or expanded programs
   - the ranking of specific program recommendations based on their relative urgency.

6. There should be a detailed description of human resources redeployment and retraining needs as a result of the recommended development and modification of the mental health system.

7. The study should include a procedure involving criteria, methods and resources for continuous evaluation of mental health needs and services in the area to the year 2000, including cost benefit analysis.

8. The consultant's final report shall be prepared in both French and English, e.i. 20 bi-lingual copies.

9. As an integral part of the study, there shall be a consultation process by which the community at large (northeastern Ontario) is given the opportunity to provide input through written briefs and consultation sessions.

Requirements

The Needs Assessment will include, but not be limited to:

- an analysis of existing and projected demographics for the region to the year 2000
- comprehensive survey of mental health care users in the region with regard to demographics, diagnoses, disposition, etc.
- projected needs of mental health care clients in the region to the year 2000
- descriptive survey and analysis of the current mental health services in the region
- utilization levels of the current mental health services in the region
- current resource requirements for the provision of mental health care services
- deployment of appropriate resources (people & facilities) to meet mental health care needs to the year 2000
- description and explanation of evaluation procedures and tools to monitor mental health care needs and services to the year 2000 for the region

Timing

The study will commence immediately after the contract is awarded. The Ministry wishes to study to be completed within six months, with draft report(s) and final report to follow within one month.

Reporting

A Steering Committee comprising local representatives of northeastern Ontario will guide the study. Additionally, Ministry of Health staff will serve as members of the Committee and as resource personnel.

The Steering Committee will:

1. Participate with the Ministry in:
    - coordinating the call for tenders
    - evaluating proposals
    - selecting the successful proposer (consultant)
2. Establish a system of check points with the consultant to monitor the study process:
    - relevant providers and consumers are consulted
    - all necessary and appropriate information is collected
    - information is accurately analysed and interpreted in keeping with the study objectives
3. Review consultant's draft report(s) and discuss possible revisions to ensure the final report fulfils the study terms of reference.

All working papers, draft report(s) and the final report shall be the property of the Ontario Ministry of Health at termination of the study project.

Proposal Content

Proposals should include the following:

- a statement of the purpose of the study as you understand it and a statement of the product to be provided
- an outline of the study method and the supporting rationale for this approach
- a description of the methodology which includes identification of the scope and limitations of the methodology
- the elapsed time required for the study and the time associated with components of the study

- the names of personnel who will be assigned to the study, their qualifications, and experience
- the extent of time to be given to the study by individual personnel assigned to the project
- the names of any sub-contractors who may be utilized and their roles related to the project
- the relevant experience of the consulting group in similar studies, with references for these studies
- a description of the planning and control techniques for managing the project and the working relationship with the Steering Committee
- reporting methods proposed and key points at which reporting should occur
- a chronological chart showing steps in the work plan
- a detailed budget including per diem charges for each consultant with a maximum overall cost figure (no fee is payable for proposal preparation costs)

Proposers' Meeting

To assist proposers in familiarizing themselves with the requirements of the study, a meeting will be held on Wednesday, March 20, 1985 at 10:15 a.m. in the Niagara Room of the Macdonald Block, Queen's Park, Toronto.

Selection Criteria

Proposals will be judged on the basis of the following:

- understanding of the purpose and requirements of the study
- suitability of the approach proposed for this study
- feasibility of the work plan
- the timetable for the completion of the project
- a documented demonstration that the company and the consultants proposed for the assignment have:
    - a thorough understanding of the practices and techniques involved in the project
    - an understanding of the complexities of a comprehensive regional mental health system

- successfully completed comparable assignments
- a detailed cost projection for manpower, showing individual hourly or per diem rates, cost of suplies and expenses, etc., and a firm maximum fee
- a detailed staffing projection showing who will be assigned to the project, with supporting documentation of appropriate experience for each project team member.

March 6, 1985
108-2-161

APPENDIX C

LIST OF INTERVIEWEES AND COMMUNITY CONSULTATIONS

OVERVIEW OF INTERVIEWS, PUBLIC CONSULTATION AND MODEL TESTING SESSIONS

This appendix includes a summary of the process and range of organizations consulted during the course of this study from October, 1985 through May, 1986. To this end, it includes a list of preliminary interviews in October and November 1985 to collect broad input to the study and information on current service providers and other key players. In January, public consultations were advertised, encouraging consumers and the general public to share their impressions on mental health services and needs within their areas, many of providers seen in the first round of interviews provided input along with many of the general public including ex-psychiatric patients.

The third phase of community consultation included model testing sessions, where the Steering Committee and consultants presented a proposed model. Invitees to these sessions were key provider groups and agencies which will be important players in implementation and in the future mental health system. The following lists reflect telephone contacts as well as personal interviews.

INITIAL INTERVIEWS

In October and November, 1985 visits were made to the Northeast, when various organizations and individuals were interviewed as part of the study.

Organizations which are shown, were sometimes represented by more than one individual and where appropriate, groups with representations from a variety of agencies were interviewed together, such as in Sturgeon Falls where various providers and related public service agencies were assembled for a group interview.

A priority of this process was to meet with the designated mental health service providers such as hospitals with in-patient psychiatry beds and community mental health funded programs to ensure their direct input to the study.

As one requirement in the terms of reference for the study was that the Steering Committee consider the possible integration of adult and children's mental health services. Consequently, various MCSS-funded children's groups and educational representatives were contacted, including:

- family life centres;
- children's aid societies;

- crisis housing and family resource centres;
- associations for the mentally retarded; and
- boards of education.

In hospitals, administration, medical staff, boards of directors and other professionals may have provided direct input.

Operators of homes for special care in several areas attended group meetings. As well, group meetings were held with the Association of Northeast Homes For The Aged.

The following list contains organizations, individual practitioners and agencies which provided input to the study, represented through these various meetings and interviews.

ALGOMA

Associations, Interest Groups, Agencies

Addiction Research Foundation, Sault Ste. Marie

Algoma District Health Council, Sault Ste. Marie

Algoma North Counselling Service, Wawa

Association for the Mentally Retarded, Sault Ste. Marie

Developmental Assessment Service, Sault Ste. Marie

East Algoma Mental Health Services Task Force, Sault Ste. Marie

Extendicare, Sault Ste. Marie

Family Life Centre, Elliot Lake

Family Violence Intervention Program, Sault Ste. Marie

Friends of Schizophrenics, Sault Ste. Marie

Health and Welfare Canada, Medical Services, Sault Ste. Marie

Indian Friendship Centre, Sault Ste. Marie

John Howard Society, Sault Ste. Marie

Ministry of Community and Social Services District Office, Sault Ste. Marie

Ministry of Northern Affairs, Sault Ste. Marie

Parents Anonymous, Sault Ste. Marie

Recovery Incorporated, Sault Ste. Marie

Sault Ste. Marie and District Group Health Association, Sault Ste. Marie

Telecare, Elliot Lake

Telecare, Sault Ste. Marie

Tendercare Nursing Homes, Sault Ste. Marie

Van Daele Manor, Extendicare, Sault Ste. Marie

Victorian Order of Nurses, Sault Ste. Marie

Women In Crisis Outreach, Sault Ste. Marie

Women's Recovery Home, Sault Ste. Marie

Children's Services

Children's Aid Society, Sault Ste. Marie

Family Services Centre, Sault Ste. Marie

Funded Community Mental Health Programs

Canadian Mental Health Association, Sault Ste. Marie

Medirep, Riverview Centre, Plummer Memorial Hospital, Sault Ste. Marie

Beginnings Transition House, Sault Ste. Marie

Camillus Centre Alcohol Treatment Program, Elliot Lake

P.A.R. Mental Health, Sault Ste. Marie

Plummer Memorial Detox Centre, Sault Ste. Marie

General Practitioners and Psychiatrists

Dr. J.F. Schwartzl, Sault Ste. Marie

Dr. Tang, Sault Ste. Marie

Hospitals and Health Units

Algoma District Health Unit, Sault Ste. Marie

Hornepayne Community Hospital, Hornepayne

Plummer Memorial Hospital, Sault Ste. Marie

St. Joseph's General Hospital, Elliot Lake

Sault Ste. Marie General Hospital, Sault Ste. Marie

COCHRANE

Associations, Interest Groups, Agencies

ACFO, Cochrane District

ACFO Hearst

ACFO Timmins

Addiction Research Foundation, Alcoholism and Drug Addiction Research Foundation, Timmins

Association for the Mentally Retarded, Timmins

Cochrane District Health Council, Timmins

Cochrane District Health Council, Mental Health Sub-Committee, Timmins

Cochrane Temiskaming Resource Centre, South Porcupine

Community Association of Timmins, Timmins

Cor Jesu, Timmins

Correctional Services Canada, Timmins

Family Resource Centre, Matheson

Grand Council Treaty #9 (representatives)

Ministry of Community and Social Services District Office, Timmins

Moose Factory Band, Moose Factory

National Native Alcohol and Drug Abuse Program, Moose Factory

National Parole Service, Cochrane

Ontario Provincial Police, South Porcupine

Roman Catholic Diocese Family Counselling Centre, Timmins

Service de Toxicomarie Inc., North Cochrane Addiction Services Inc., Kapuskasing

Telecare, Timmins

Children's Services

Children's Aid Society, Kapuskasing

Children's Aid Society, Timmins

Children's Mental Health Services, Moosonee

Porcupine and District Children's Aid Society, Timmins

South Cochrane Child and Youth Services, Timmins

Funded Community Mental Health Programs

CMHA/Timmins Lifeline Program, Timmins

Canadian Mental Health Association, Kirkland Lake

Maison Renaissance Inc., Hearst

Mid-Step Program, St. Mary's General Hospital, Timmins

Minto Counselling Centre, Cochrane

North Cochrane Mental Health Services, Kapuskasing

North Cochrane Addiction Services Inc., Kapuskasing

Sensenbrenner Community Mental Health Services, Kapuskasing

General Practitioners and Psychiatrists

Dr. Haskens, Iroquois Falls

Dr. R. Killingbeck, Matheson

Dr. P. Logan, Matheson

Dr. J. Slater, Cochrane

Hospitals and Health Units

Lady Minto Hospital, Cochrane

Moose Factory General Hospital, Moose Factory

Moosonee James Bay General Hospital, Moosonee

Notre Dame Hospital, Hearst

Porcupine General Hospital, Timmins

Porcupine Health Unit, Timmins

St. Mary's General Hospital, Timmins

Timmins District Hospital, Timmins

NIPISSING/TIMISKAMING

Associations, Interest Groups, Agencies

ACFO/Nipissing, North Bay

Association for the Mentally Retarded, North Bay

Canadore College, North Bay

Centre Concordia Pavillon Culturel, Sturgeon Falls

Chateau Nursing Home, Kirkland Home, Kirkland Lake

Community Contact, Kirkland Lake

Norm Critchley - architect, North Bay

Extendicare/Kirkland Nursing Home, Kirkland Lake

Family Life Centre, North Bay

Harmony House Inc., Kirkland Lake

Indian Friendship Centre, North Bay

Industrial Commission, Sturgeon Falls

Lawrence Commanda Health Centre, Garden Village

Mayor Stan Lawlor, North Bay

Ministry of Community and Social Services District Office, North Bay

Nipissing District Social Services

North Bay Crisis Centre, North Bay

North Bay Ratepayers Group

OPSEU, North Bay

Ontario Provincial Police, Kirkland Lake

Pavillion Family Resource Centre, Haileybury

Police Department, Kirkland Lake

Police Department, Sturgeon Falls

Recovery Inc., North Bay

St. Joseph's Centre, North Bay

The Salvation Army, Kirkland Lake

West Nipissing Association for the Mentally Retarded

West Nipissing Public Services

West Nipissing Social Services Association

Victorian Order of Nurses, North Bay

Children's Services

Children's Mental Health Centre, Parry Sound

Child and Youth Services of Timiskaming, Kirkland Lake

Concordia Centre, North Bay

Family and Children's Services Society, Kirkland Lake

Family and Children's Services, North Bay

Nipissing Children's Services, North Bay

Nipissing Children's Services Co-ordinating and Advisory Group (CSCAG)

Kirkland Lake Educational System Representatives:
- Doug Cooper, Head of Student Services
- Claire Bouillion, Counsellor
- Brian Bronson, Counsellor
- Pat Arnie, Counsellor

Funded Community Mental Health Programs

Canadian Mental Health Association/Drop-In Centre, North Bay

Community Mental Health Service, Bracebridge

Crisis Centre, North Bay

Mental Health Services Board, North Bay

North Bay Mental Health Services, North Bay

West Nipissing Alliance Centre

General Practitioners and Psychiatrists

Dr. K.E. Badoe, North Bay

Dr. A. Boafo, North Bay

Dr. E. Hlasek, North Bay

Dr. D.V. Krishnaprasad, North Bay

Dr. E.A. O'Toole, North Bay

Dr. Yip Tong, North Bay
as well, a group meeting was available to all medical staff at NBPH.

Hospitals and Health Units

Kirkland and District Hospital, Kirkland Lake

New Liskeard Hospital, New Liskeard

North Bay and District Health Unit, North Bay

North Bay Civic Hospital, North Bay

North Bay Psychiatric Hospital, North Bay and department representatives:
- Nursing
- Support Services
- Education
- Medical Staff
- Out-Patient Departments
- Occupational Therapy
- Information Officer
- Patient Advocate
- Psychology
- Social Work

St. Joseph's General Hospital, North Bay

Timiskaming Health Unit, Mental Health Program, Kirkland Lake

West Nipissing General Hospital, Sturgeon Falls

MANITOULIN/SUDBURY

Associations, Interest Groups, Agencies

ACFO, Sudbury

Addiction Research Foundation/Alcoholism and Drug Addiction Research Foundation, Sudbury

Association for the Mentally Retarded, Sudbury

Extendicare Sudbury, Falconbridge, Sudbury

Extendicare Sudbury, York Nursing Home, Sudbury

Indian Eskimo Friendship Centre, Sudbury

Manitoulin Sudbury District Health Council, Sudbury

Men's Social Services Salvation Army Alcoholic Treatment Clinic, Sudbury

Ministry of Community and Social Services, District Office, Sudbury

Ministry of Northern Development and Mines, Sudbury

N'Swaknok Native Friendship Centre, Sudbury

Ontario Friends of Schizophrenics, Sudbury

Recovery Inc., Sudbury

Service Familial de la Region de Sudbury Inc., Sudbury

Telecare, Sudbury

United Chiefs and Councils of Manitoulin Island

Wikwimikong Mental Health Program, Sudbury

Wikwimikong Nursing Home, Sudbury

Children's Services

Centre Des Jeunes de Sudbury, Inc., Sudbury

Children's Aid Society, Sudbury

Children's Services Committee, Sudbury

Manitoulin Board of Education, Little Current

Probation and After Care, Children's Services Division, Sudbury

Funded Community Mental Health Programs

Canadian Mental Health Association, Lively

Crisis Intervention Program, Sudbury General Hospital, Sudbury

Depression Management and Suicide Prevention, Manitoulin

Expanded Psychiatric Day Care Program, Sudbury

Sudbury Algoma Hospital - Clinics Program

GPs and Psychiatric Medical Professionals

Dr. J.C. Crosbie, Sudbury

Dr. G.M. Irvine, Sudbury

Dr. Y. Kwasnie, Sudbury

Dr. E.C. MacLeod, Sudbury

Dr. McFarthing, Sudbury

Hospitals and Health Units

Manitoulin Health Centre, Little Current

Sudbury Algoma Hospital, Sudbury

Sudbury and District Health Unit, Sudbury

Sudbury General Hospital, Sudbury

Sudbury Laurentian Hospital, Sudbury

Sudbury Memorial Hospital, Sudbury

* * * * *

The following interviews were conducted relevant to all service areas and/or as relevant to this overall study.

Associations, Interest Groups, Agencies

Indian Commissioner of Ontario

Ministry of Indian and Northern Affairs

National Health and Welfare

Northeast Ontario Association Homes for the Aged:
  West Nipissing Homes for the Aged
  Au Chateau Home for the Aged, Sturgeon Falls
  South Centennial Manor, Iroquois Falls
  Cochrane District Homes for the Aged
  Cassellholme, North Bay
  Manitoulin Centennial Manor, Little Current
  Pioneer Manor, Sudbury
  North Centennial Manor, Kapuskasing

Northern Health Services Division of Health and Welfare Canada

Ministry of Community and Social Services - Assistant Deputy Minister

Minister of Health

General Practitioners and Psychiatrists

Dr. Heseltine (Psychiatrist) author of Blue Print For Change

Dr. Barry Humphries

Dr. Kern, University of Western Ontario, Division of Research and Education

Dr. Dan Offord - McMaster

Dr. Bernard Proulx

Dr. Naomi Rae-Grant

Dr. Quentin Rae-Grant

Dr. Reichenfeld - Ottawa - Carleton Program

PUBLIC MEETINGS

In January, 1986, the general public was invited to attend public meetings to discuss mental health issues and concerns in the following cities:

- North Bay
- Kirkland Lake
- Cochrane
- Timmins
- Sudbury
- Elliot Lake
- Sault Ste. Marie

Attendance at these sessions ranged from three attendants in Cochrane to 58 in Sault Ste. Marie. Participants represented a wide variety of groups including ex-psychiatric patients, mental health providers, the press, interested agencies and associations, and private citizens. Over 160 people attended these sessions.

MODEL TESTING SESSIONS

In May of 1986 the Steering Committee returned to the community for a third time to test the proposed model and to solicit feedback from key providers and interest groups in order to ensure the appropriateness of recommendations and to identify issues impacting implementation. Sessions were held with the following groups:

- North Bay Psychiatric Hospital Administration, Medical Representation, Senior/Middle Management Group
- North Bay Health Agencies Group
- Ontario Public Services Employee's Union Representatives
- Planning Board of the New North Bay Hospital
- Sudbury Algoma Hospital
- Manitoulin/Sudbury District Health Council - Mental Health Sub-Committee and invited guests
- Sudbury General Hospital
- Cochrane District Health Council - Mental Health Sub-Committee and invited providers/guests
- Algoma District Health Council - Mental Health Sub-Committee
- A selected group of providers from the Algoma/Sault Ste. Marie area
- Association of Children's Mental Health Centres - Northeast Ontario representatives
- Advisory Board to Timiskaming Public Health Unit Mental Health Program - New Liskeard
- Minister of Health

These sessions proved very useful, in assisting the Steering Committee to finalize the model for Northeast Ontario and to identify implementation considerations.

APPENDIX E

POPULATION PROJECTIONS
TO YEAR 2001
AND DEMOGRAPHIC DATA
FOR
NORTHEAST ONTARIO AND SERVICE AREAS

ACTUAL AND PROJECTED ONTARIO POPULATION BY AGE GROUPS AND SEX, SELECTED YEARS, 1981-2001

	ACTUAL			PROJECTED POPULATION											
	1981[1]			1986[2]			1991[2]			1996[2]			2001[2]		
UP	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
	4,246,785	4,378,320	8,625,105	4,501,700	4,660,800	9,162,500	4,715,600	4,898,700	9,614,200	4,879,600	5,083,600	9,963,200	5,006,100	5,230,000	10,236,200
	967,715	918,950	1,886,665	963,600	917,000	1,880,600	982,000	937,800	1,919,800	989,800	946,400	1,936,100	962,500	920,200	1,882,700
	413,355	395,510	808,865	355,700	339,600	695,300	332,800	316,000	648,800	323,700	309,400	633,000	339,400	325,500	665,000
	392,665	397,030	789,695	424,500	412,200	836,700	363,000	351,000	713,900	338,200	325,000	663,200	329,100	318,400	647,500
	715,890	740,380	1,456,270	777,300	803,000	1,580,300	848,400	848,600	1,697,100	809,200	792,300	1,601,400	721,300	702,400	1,423,700
	538,700	534,460	1,073,160	656,400	662,500	1,318,900	737,100	762,300	1,499,400	789,900	817,200	1,607,100	856,700	859,100	1,715,800
	856,570	885,685	1,742,255	905,800	939,200	1,844,900	964,200	993,800	1,957,700	1,080,000	1,124,500	2,204,600	1,206,400	1,276,600	2,483,000
	361,890	506,305	868,195	418,300	587,200	1,005,600	488,200	689,100	1,177,400	548,900	768,900	1,317,800	590,700	827,700	1,418,500
ST ONTARIO	276,175	273,435	549,610	282,347	282,089	564,436	286,403	288,339	574,742	288,959	292,845	581,804	289,022	294,594	583,616
	70,140	66,780	136,920	65,743	62,666	128,409	64,097	61,282	125,379	63,544	60,787	124,331	61,470	58,811	120,281
	30,735	29,625	60,360	24,635	23,561	48,196	22,415	21,315	43,730	20,295	19,437	39,732	19,935	19,117	39,052
	25,560	25,575	51,135	30,120	29,250	59,370	23,960	23,073	47,033	21,840	20,906	42,746	19,787	19,085	38,872
	43,110	42,780	85,890	46,391	46,942	93,333	53,737	53,243	106,980	51,942	50,598	102,540	44,109	42,659	86,768
	32,800	32,180	64,980	37,584	36,649	74,233	40,571	40,335	80,906	43,457	44,100	87,557	50,649	50,355	101,004
	53,410	52,155	105,565	54,931	54,170	109,101	55,630	55,408	111,038	59,036	59,612	118,648	62,590	64,224	126,814
	20,420	24,340	44,760	22,943	28,851	51,794	25,993	33,683	59,676	28,845	37,405	66,250	30,482	40,343	70,825
	67,380	66,175	133,555	71,819	71,026	142,845	74,376	74,029	148,405	76,313	76,431	152,744	77,583	78,176	155,759
	17,025	16,345	33,370	16,734	16,267	33,001	16,833	16,167	33,000	16,726	15,991	32,717	16,187	15,478	31,665
	7,280	6,970	14,250	6,176	5,724	11,900	5,532	5,498	11,030	5,413	5,263	10,676	5,466	5,237	10,703
	6,850	6,800	13,650	7,373	7,121	14,494	6,099	5,690	11,789	5,465	5,466	10,931	5,352	5,240	10,592
	11,085	10,615	21,700	12,925	12,730	25,655	14,173	13,971	28,144	13,227	12,661	25,888	11,376	11,054	22,430
	8,060	7,755	15,815	9,474	9,159	18,633	11,010	10,566	21,576	12,527	12,377	24,904	13,745	13,597	27,342
	12,765	12,235	25,000	13,845	13,362	27,207	14,393	14,145	28,538	15,520	15,365	30,885	17,255	17,160	34,415
	4,315	5,455	9,770	5,292	6,663	11,955	6,336	7,992	14,328	7,435	9,308	16,743	8,202	10,410	18,612
	49,580	47,310	96,890	51,054	49,321	100,375	52,215	50,953	103,168	53,118	52,250	105,368	53,597	53,072	106,669
	12,825	12,125	24,950	12,761	12,048	24,809	13,130	12,478	25,608	13,422	12,847	26,269	12,910	12,357	25,267
	5,400	5,140	10,540	4,351	4,195	8,546	3,997	3,759	7,756	3,815	3,574	7,389	4,254	4,082	8,336
	5,025	4,690	9,715	5,252	5,032	10,284	4,203	4,081	8,284	3,872	3,664	7,536	3,704	3,490	7,194
	8,120	7,645	15,765	9,071	8,521	17,592	9,822	9,333	19,155	8,989	8,722	17,711	7,704	7,439	15,143
	5,555	5,340	10,895	6,602	6,199	12,801	7,545	7,096	14,641	8,436	7,909	16,345	9,167	8,719	17,886
	8,985	8,395	17,380	9,090	8,724	17,814	9,186	8,917	18,103	9,894	9,675	19,569	11,019	10,773	21,792
	3,670	3,975	7,645	3,927	4,602	8,529	4,332	5,289	9,621	4,690	5,859	10,549	4,839	6,212	11,051
/TIMISKAMING	60,145	61,290	121,435	60,347	62,149	122,496	60,255	62,499	122,754	59,990	62,534	122,524	59,243	61,935	121,178
	14,780	13,915	28,695	13,620	12,909	26,529	13,346	12,745	26,091	13,403	12,826	26,229	12,920	12,364	25,284
	6,855	6,720	13,575	5,319	5,004	10,323	4,625	4,342	8,967	4,057	3,870	7,927	4,093	3,929	8,022
	5,280	5,155	10,435	6,682	6,602	13,284	5,136	4,864	10,000	4,470	4,224	8,694	3,921	3,768	7,689
	8,650	8,855	17,505	9,239	9,301	18,540	11,411	11,289	22,700	11,232	10,981	22,213	9,143	8,714	17,857
	7,060	7,210	14,270	7,782	7,907	15,689	7,965	8,193	16,158	8,474	8,549	17,023	10,602	10,530	21,132
	11,900	12,390	24,290	11,954	12,422	24,376	11,870	12,280	24,150	12,377	13,000	25,377	12,358	13,289	25,647
	5,620	7,045	12,665	5,751	8,004	13,755	5,902	8,786	14,688	5,977	9,084	15,061	6,206	9,341	15,547
/SUDBURY	99,070	98,660	197,730	99,127	99,593	198,720	99,557	100,858	200,415	99,538	101,630	201,168	98,599	101,411	200,010
	25,510	24,395	49,905	22,628	21,442	44,070	20,788	19,892	40,680	19,993	19,123	39,116	19,453	18,612	38,065
	11,200	10,795	21,995	8,789	8,638	17,427	8,261	7,716	15,977	7,010	6,730	13,740	6,122	5,869	11,991
	8,405	8,930	17,335	10,813	10,495	21,308	8,522	8,438	16,960	8,033	7,552	15,585	6,810	6,587	13,397
	15,255	15,665	30,920	15,156	16,390	31,546	18,331	18,650	36,981	18,494	18,234	36,728	15,886	15,452	31,338
	12,125	11,875	24,000	13,726	13,384	27,110	14,051	14,480	28,531	14,020	15,265	29,285	17,135	17,509	34,644
	19,760	19,135	38,895	20,042	19,662	39,704	20,181	20,066	40,247	21,245	21,572	42,817	21,958	23,002	44,960
	6,815	7,865	14,680	7,973	9,582	17,555	9,423	11,616	21,039	10,743	13,154	23,897	11,235	14,380	25,615

IGURES MAY NOT ADD TO TOTALS DUE TO ROUNDING.

SOURCE: 1. STATISTICS CANADA, CATALOGUE 93-X-918, TABLE 1.
2. ECONOMIC POLICY BRANCH, OFFICE OF ECONOMIC POLICY, ONTARIO MINISTRY OF TREASURY AND ECONOMICS, AUGUST 1985.

SUMMARY OF DEMOGRAPHIC DATA - 1

Characteristics	ONTARIO	NORTH-EASTERN ONTARIO	ALGOMA	COCHRANE	NIPISSING/TIMISKA-MING	MANITOULIN/SUDBURY
POPULATION	8,625,105	549,832	133,553	96,875	121,556	197,848
0-14 yrs. male	967,715	70,260	16,960	12,850	14,780	25,670
female	918,950	66,790	16,425	12,125	13,830	24,410
total	1,886,665	137,050	33,385	24,975	28,610	50,080
15-44 yrs. male	2,060,610	132,055	33,295	24,065	27,855	46,840
female	2,067,380	130,330	32,215	22,785	28,025	47,305
total	4,127,990	262,385	65,510	46,850	55,880	94,145
45-64 yrs. male	856,570	53,370	12,785	8,945	11,945	19,695
female	885,685	52,050	12,155	8,375	12,375	19,145
total	1,742,255	105,420	24,940	17,320	24,320	38,840
65+ yrs. male	361,890	20,650	4,305	3,715	5,735	6,895
female	506,305	24,310	5,420	4,010	6,995	7,885
total	868,195	44,960	9,725	7,725	12,730	14,780
NUMBER OF RESERVES IN DISTRICT		25	8	3	3	11
POPULATION OF RESERVES		8,634	2,232	2,018	871	3,513
LAND AREA IN SQ. KM.	916,773.70	277,102.89	51,206.90	145,618.01	30,716.98	49,561.0
POPULATION DENSITY BY SQ. KM.	9.4	2.0	2.6	0.7	4.0	4.0
URBAN POPULATION		409,417	99,528	66,854	87,285	155,400
RURAL POPULATION		140,765	34,025	30,021	34,271	42,448
MOTHER TONGUE						
English	6,678,770	346,605	103,475	42,445	81,445	119,240
French	475,605	150,975	13,355	46,460	34,110	57,050
Other	1,470,735	52,230	16,715	7,970	5,990	21,555
LABOUR FORCE ACTIVITY						
Males in labour force 15 yrs. and over	2,585,750	154,605	39,990	27,410	32,910	54,295
Females in labour force 15 yrs. and over	1,878,300	94,735	24,295	15,590	21,140	33,710
AVERAGE INCOME						
Males 15 yrs. and over with income	$17,517	$16,742	$18,302	$16,743	$14,969	$16,757
Females 15 yrs. and over with income	$ 8,635	$ 7,120	$ 7,203	$ 7,212	$ 6,914	$ 7,156
FAMILY DATA						
Widowed	436,440	25,235	5,665	4,370	6,710	8,490
Divorced	167,935	8,060	2,270	1,055	1,875	2,860
Private Household						
with 1 person	611,260	32,040	7,205	5,505	7,910	10,790
average number of persons per private household	2.8	3.0	2.8	3.1	2.9	3.1
Families in private households	2,278,975	141,925	34,710	24,435	31,395	51,365
Husband-wife families	2,028,690	125,720	30,950	21,755	27,625	45,370
Lone-parent families	250,285	16,205	3,760	2,680	3,770	5,995
Average number of children per family	1.3	1.5	1.3	1.6	1.5	1.5
Number of persons 15 yrs. and over with less than Grade 9 schooling	1,160,335	91,900	19,310	18,745	20,765	33,080

Source: Statistics Canada, Catalogue 93-x-942, Table 1, 1981
Statistics Canada, Catalogue 93-x-918, Table 1, 1981
Statistics Canada, Catalogue 93-906, Table 2, 1981

APPENDIX F

CONTACTS FOR INFORMATION ON SELECTED PROGRAMS

CONTACTS FOR INFORMATION ON SELECTED PROGRAMS

For information on the following programs, contact the identified individuals:

- **Oakville-Trafalgar Hospital**
  SIL Program

  Dr. E. Bussé
  (416) 845-9606

- **Progress Place, North York**

  Ms. Brenda Singer, Executive Director
  (416) 225-3173

- **Halton Region Job Development Program**
  (The Bronte Labour Exchange)

  Ms. Debby Gaines
  (416) 845-2571, ext. 358 or 374

- **Sudbury Algoma Hospital**
  Addictions Services Program

  Mr. Brian Valin, Executive Director
  (705) 675-9192